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**State:** Tennessee **Filing Company:** BEST Life and Health Insurance Company  
**TOI/Sub-TOI:** H10I Individual Health - Dental/H10I.000 Health - Dental  
**Product Name:** Stand Alone Dental - Individual Market  
**Project Name/Number:** Form Filing/Exchange Products

## Filing at a Glance

Company: BEST Life and Health Insurance Company  
Product Name: Stand Alone Dental - Individual Market  
State: Tennessee  
TOI: H10I Individual Health - Dental  
Sub-TOI: H10I.000 Health - Dental  
Filing Type: Form/Rate  
Date Submitted: 04/30/2013  
SERFF Tr Num: BLHI-129004054  
SERFF Status: Closed-Approved  
State Tr Num: H-130559  
State Status: Approved  
Co Tr Num: FORM FILING

Implementation: 01/01/2014  
Date Requested:  
Author(s): Paul Peatross, Margie Mergen  
Reviewer(s): Vicky Stotzer (primary), Brian Hoffmeister, Melissa Merritt, Art Lucker  
Disposition Date: 08/12/2013  
Disposition Status: Approved  
Implementation Date:

State Filing Description:  
Assoc G DEN HIX P  
GPD-IM-PPO-POL-0113TN  
association group stand alone dental for HIX

**State:** Tennessee  
**TOI/Sub-TOI:** H101 Individual Health - Dental/H101.000 Health - Dental  
**Product Name:** Stand Alone Dental - Individual Market  
**Project Name/Number:** Form Filing/Exchange Products

**Filing Company:** BEST Life and Health Insurance Company

## General Information

Project Name: Form Filing  
Project Number: Exchange Products  
Requested Filing Mode: Review & Approval

Explanation for Combination/Other:  
Submission Type: New Submission  
Overall Rate Impact:

Deemer Date:  
Submitted By: Margie Mergen

Status of Filing in Domicile: Not Filed  
Date Approved in Domicile:  
Domicile Status Comments: BEST Life is domiciled in Texas.  
This filing has not been submitted in Texas.  
Market Type: Individual  
Individual Market Type:  
Filing Status Changed: 08/12/2013  
State Status Changed: 08/12/2013  
Created By: Margie Mergen  
Corresponding Filing Tracking Number:

Filing Description:  
BEST Life and Health Insurance Company – NAIC No. 90638  
FEIN: 95-6042390

List of Forms:  
GAD-IM-PPO-POL-0113TN - Association Adult Dental Policy  
GAD-IM-PPO-CERT-0113TN - Adult Dental Certificate  
GAD-IM-PPO-SOV-0113TN - Adult Dental Statement of Variability  
GPD-IM-PPO-POL-0113TN - Association Pediatric Dental Policy  
GPD-IM-PPO-CERT-0113TN - Pediatric Dental Certificate  
GPD-IM-PPO-SOV-0113TN - Pediatric Dental Statement of Variability

Dear Sir or Madam,

On behalf of BEST Life and Health Insurance Company, please find enclosed the Forms Filing . This filing is to meet the requirements for offering stand alone dental in the Tennessee Exchange. Our filing includes 2 products for the Individual Market. These forms do not replace previously filed forms and do not deviate from generally accepted standard insurance practices.

These stand alone dental plans are being offered through the BEST Employers Association, a California corporation ("BEA"). BEA was incorporated in 1970, and was created for the purpose of promoting healthy behaviors among its members. The forms will correspond to the following Exchange markets as follows:

For the Individual Market:  
- Pediatric Only EHB Dental Plan: - GPD-IM-PPO-CERT-0113TN  
- Adult (without Pediatric EHB) - GAD-IM-PPO-CERT-0113TN

Should you have any questions or concerns regarding this filing, please contact me directly at the number listed below or via email. I appreciate your time and consideration.

Sincerely,

**State:** Tennessee **Filing Company:** BEST Life and Health Insurance Company  
**TOI/Sub-TOI:** H101 Individual Health - Dental/H101.000 Health - Dental  
**Product Name:** Stand Alone Dental - Individual Market  
**Project Name/Number:** Form Filing/Exchange Products

Margie Mergen  
Compliance Analyst  
BEST Life and Health Insurance Company  
1-800-433-0088, ext. 226  
Fax: 949-222-1004  
Email: mmergen@bestlife.com

## Company and Contact

### Filing Contact Information

Paul Peatross, Senior Vice President      ppeatross@bestlife.com  
2505 McCabe Way      949-222-2118 [Phone]  
Irvine, CA 92614

### Filing Company Information

BEST Life and Health Insurance Company	CoCode: 90638	State of Domicile: Texas
2505 McCabe Way	Group Code:	Company Type:
Irvine, CA 92623	Group Name:	State ID Number:
(800) 433-0088 ext. [Phone]	FEIN Number: 95-6042390	

## Filing Fees

Fee Required? Yes  
Fee Amount: \$100.00  
Retaliatory? Yes  
Fee Explanation: TX charges \$100 per form filing.  
Per Company: No

Company	Amount	Date Processed	Transaction #
BEST Life and Health Insurance Company	\$100.00	04/30/2013	69862449

<b>State:</b>	Tennessee	<b>Filing Company:</b>	BEST Life and Health Insurance Company
<b>TOI/Sub-TOI:</b>	H10I Individual Health - Dental/H10I.000 Health - Dental		
<b>Product Name:</b>	Stand Alone Dental - Individual Market		
<b>Project Name/Number:</b>	Form Filing/Exchange Products		

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved	Vicky Stotzer	08/12/2013	08/12/2013

### Objection Letters and Response Letters

#### Objection Letters

Status	Created By	Created On	Date Submitted
Pending Company Response	Vicky Stotzer	07/31/2013	07/31/2013
Pending Company Response	Art Lucker	07/30/2013	07/30/2013
Pending Company Response	Vicky Stotzer	07/30/2013	07/30/2013
Pending Company Response	Art Lucker	07/24/2013	07/24/2013
Pending Company Response	Art Lucker	07/12/2013	07/12/2013
Pending Company Response	Melissa Merritt	05/31/2013	05/31/2013

#### Response Letters

Responded By	Created On	Date Submitted
Paul Peatross	08/09/2013	08/09/2013
Paul Peatross	07/31/2013	07/31/2013
Paul Peatross	07/31/2013	07/31/2013
Margie Mergen	07/26/2013	07/26/2013
Margie Mergen	07/18/2013	07/18/2013
Margie Mergen	06/13/2013	06/13/2013

<b>State:</b>	Tennessee	<b>Filing Company:</b>	BEST Life and Health Insurance Company
<b>TOI/Sub-TOI:</b>	H10I Individual Health - Dental/H10I.000 Health - Dental		
<b>Product Name:</b>	Stand Alone Dental - Individual Market		
<b>Project Name/Number:</b>	Form Filing/Exchange Products		

## Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Deadline Has Passed	Note To Filer	Brian Hoffmeister	08/01/2013	08/01/2013
HIOS	Note To Filer	Vicky Stotzer	07/31/2013	07/31/2013
HIOS and SERFF	Note To Reviewer	Paul Peatross	07/31/2013	07/31/2013
Forms	Note To Filer	Vicky Stotzer	07/31/2013	07/31/2013
Forms	Note To Reviewer	Paul Peatross	07/31/2013	07/31/2013
Time Limit	Note To Filer	Vicky Stotzer	07/31/2013	07/31/2013
Note regarding last objection	Note To Filer	Vicky Stotzer	07/30/2013	07/30/2013
Response Needed	Note To Filer	Brian Hoffmeister	07/17/2013	07/17/2013

<b>State:</b>	Tennessee	<b>Filing Company:</b>	BEST Life and Health Insurance Company
<b>TOI/Sub-TOI:</b>	H10I Individual Health - Dental/H10I.000 Health - Dental		
<b>Product Name:</b>	Stand Alone Dental - Individual Market		
<b>Project Name/Number:</b>	Form Filing/Exchange Products		

## Disposition

Disposition Date: 08/12/2013

Implementation Date:

Status: Approved

Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
BEST Life and Health Insurance Company	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Cover Letter Accident & Health	Approved	Yes
Supporting Document	Description of Variables	Approved	Yes
Supporting Document	Filing Fees	Approved	Yes
Supporting Document	Readability Certification	Approved	Yes
Supporting Document	Third Party Authorization	Approved	Yes
Supporting Document	Actuarial Memorandum A & H Certification - Individual	Approved	Yes
Supporting Document	Accident & Health - Individual New Rates	Approved	Yes
Supporting Document (revised)	Response to Objections to Rates	Approved	Yes
Supporting Document	Response to Objections to Rates	Replaced	Yes
Supporting Document (revised)	redline	Approved	Yes
Supporting Document	redline	Replaced	Yes
Form (revised)	Individual Market Pediatric Dental Group Policy	Approved	Yes
Form (revised)	Individual Market Pediatric Dental Certificate	Approved	Yes

<b>State:</b>	Tennessee	<b>Filing Company:</b>	BEST Life and Health Insurance Company
<b>TOI/Sub-TOI:</b>	H10I Individual Health - Dental/H10I.000 Health - Dental		
<b>Product Name:</b>	Stand Alone Dental - Individual Market		
<b>Project Name/Number:</b>	Form Filing/Exchange Products		

Schedule	Schedule Item	Schedule Item Status	Public Access
Form (revised)	Individual Market Pediatric Dental Statement of Variability	Approved	Yes
Form (revised)	Individual Market Family or Child Dental Policy	Approved	Yes
Form (revised)	Individual Market Family or Child Outline of Coverage	Approved	Yes
Form (revised)	Individual Market Family Dental Variability Statement	Approved	Yes
Form	Individual Market Pediatric Dental Group Policy	Replaced	Yes
Form	Individual Market Pediatric Dental Group Policy	Replaced	Yes
Form	Individual Market Pediatric Dental Group Policy	Replaced	Yes
Form	Individual Market Pediatric Dental Certificate	Approved	Yes
Form	Individual Market Pediatric Dental Statement of Variability	Replaced	Yes
Form	Individual Market Family or Child Dental Policy	Replaced	Yes
Form	Individual Market Adult Dental Policy	Replaced	Yes
Form	Individual Market Family or Child Outline of Coverage	Replaced	Yes
Form	Individual Market Adult Dental Certificate	Replaced	Yes
Form	Individual Market Adult Dental Variability Statement	Replaced	Yes
Rate (revised)	ACTUARIAL MEMORANDUM	Approved	Yes
Rate	ACTUARIAL MEMORANDUM	Replaced	Yes
Rate (revised)	PEDIATRIC RATE CALCULATIONS	Approved	Yes
Rate	PEDIATRIC RATE CALCULATIONS	Replaced	Yes
Rate (revised)	ADULT RATE CALCULATIONS	Approved	Yes
Rate	ADULT RATE CALCULATIONS	Replaced	Yes



## INS CONSULTANTS, INC.

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Insurance Regulatory Consultants

419 S. 2<sup>nd</sup> Street  
New Market, Suite 206  
Philadelphia, PA 19147  
Phone: (215) 625-9877  
Fax: (215) 627-7104

TO: Vicky Stotzer  
Health Analyst  
Policy Analysis Section, Insurance Division  
Tennessee Department of Commerce and Insurance

FROM: James Kuklinski, ASA, MAAA  
INS Consultants, Inc.

DATE: July 31, 2013

SUBJECT: BEST Life and Health Insurance Company  
Individual Health – Dental  
Forms: IFD-PPO-POL-0113TN, IFD-PPO-OC-0113TN  
SERFF tracking Number: BLHI-129004054  
Tennessee Tracking Number: H-130559

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INS Consultants, Inc. (INS) has reviewed BEST Life and Health Insurance Company's (BEST) group dental filing for plans On and Off the Tennessee Exchange. Please note that rates On and Off the exchange are the same.

This filing was submitted on April 30, 2013 requesting approval of a new Individual Family Dental Policy, and related Outline of Coverage, forms and rates, to meet both the Tennessee regulatory requirements and the Federal Affordable Care Act (ACA) requirements for offering pediatric Essential Health Benefits (EHB) using a stand-alone dental plan in the small group market. The filing covers two pediatric-only plans, Essential Pediatric High and Low, and three additional supplemental dental plans to allow for family coverage, High, Mid, and Basic; the pediatric-only plans incorporate the required pediatric dental EHB, and can each be combined with any of the supplemental plans. The six combinations of Pediatric/Supplemental plans for which rates are provided on the exchange are High/None, Low/None, High/High, High/Mid, Low/Mid, and Low/Basic. All plans are marketed On and Off the exchange. Forms and rates are requested to become effective for new business on and after January 1, 2014.

In support of their request, BEST has provided the proposed new forms and rates, an actuarial memorandum, Rate Data Template, Qualified Health Plan Application Certification, Stand-Alone Dental Plan Actuarial Value Supporting Documentation and Justification form, and Stand-Alone Dental Plans-Description of EHB Allocation form. The actuarial memorandum includes, inter alia, plan descriptions, pricing assumptions and rate derivation methodologies, the anticipated loss ratio (67.75%), and appropriate actuarial certifications.



After a review of the actuarial memorandum and related supporting materials, INS identified, on July 11, 24, and 30, several matters that required additional clarification or correction. Subsequently, on July 18 and 26, BEST provided clarification and corrections that responded to some of the questions raised by INS. Still outstanding are two objections (see Objection Letter dated July 30) requiring corrections to labeling and a correction to the renewability provision so that the coverage On the exchange is guaranteed/conditionally renewable instead of optionally renewable. The first of these corrections is basically cosmetic. The latter, though not cosmetic, would not be expected to be a problem in practice due to other contract language showing BEST's intent; however, INS notes that BEST made the appropriate corrections for the same shortcoming in the similar Tennessee filing H-130558 (as well as in corresponding filings in Iowa which INS reviewed.)

INS has reviewed the submission in its entirety. INS has checked for compliance with Tennessee loss ratio requirements, as well as for compliance with ACA requirements with respect to Actuarial Value. The anticipated loss ratio exceeds the Tennessee standard of 55% for guaranteed renewable business of this kind, and the Actuarial Values, at 85% for High plans and 70% for Low plans, fall within +/-2% of the 85% standard for High plans and 70% standard for Low plans under ACA. INS's analysis also included (but was not limited to) a review of the rate material, trend assumption, retention, administrative expense breakdown, and Rate Data Template. Based on INS's review, the rates are acceptable, the retention and administrative expenses are reasonable, the Actuarial Values appear to be calculated using a methodology that is reasonable, and the rates appear to be consistent across rating parameters and by plan differences.

Based on INS's review, and on the certifying statements of BEST's opining actuary, INS suggests that the subject filing, with the exception of the objections noted above, is compliant with Tennessee and ACA regulatory requirements. Based on this conclusion, INS suggests that the submitted rate schedules are actuarially justified.

If you have any questions or would like additional information, please do not hesitate to call or e-mail.

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James Kuklinski, ASA, MAAA

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**State:** Tennessee **Filing Company:** BEST Life and Health Insurance Company  
**TOI/Sub-TOI:** H101 Individual Health - Dental/H101.000 Health - Dental  
**Product Name:** Stand Alone Dental - Individual Market  
**Project Name/Number:** Form Filing/Exchange Products

## Objection Letter

Objection Letter Status	Pending Company Response
Objection Letter Date	07/31/2013
Submitted Date	07/31/2013
Respond By Date	

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Dear Paul Peatross,

**Introduction:**

I have reviewed your filing and conclude the above referenced submission cannot be approved for use in the State of Tennessee for the following reasons:

**Objection 1**

Comments: I am not sure what the change you made meets the request.

You need to waive the deductible for preventive services in the high option plan. The original deductibles may remain the same.

This change must be made in the policy and the certificate.

**Conclusion:**

PLEASE NOTE: The reviewer on this filing is Victoria Stotzer, if you have any questions please call her at (615) 741-6259 or through e-mail at [victoria.stotzer@tn.gov](mailto:victoria.stotzer@tn.gov).

It is unlawful, in accordance with Section 56-26-102, T.C.A. for you to utilize these forms and/or rates in Tennessee until you receive approval. This is a notice of disapproval. Your filing will be held in suspense for one hundred and twenty (120) days. If no response is received from you within this time period, your filing will be considered "disapproved" for the above stated reasons.

Sincerely,

Vicky Stotzer

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<b>State:</b>	Tennessee	<b>Filing Company:</b>	BEST Life and Health Insurance Company
<b>TOI/Sub-TOI:</b>	H101 Individual Health - Dental/H101.000 Health - Dental		
<b>Product Name:</b>	Stand Alone Dental - Individual Market		
<b>Project Name/Number:</b>	Form Filing/Exchange Products		

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## Objection Letter

Objection Letter Status	Pending Company Response
Objection Letter Date	07/30/2013
Submitted Date	07/30/2013
Respond By Date	07/31/2013

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Dear Paul Peatross,

### **Introduction:**

I have reviewed your filing and conclude the above referenced submission cannot be approved for use in the State of Tennessee for the following reasons:

### **Objection 1**

- Response to Objections to Rates (Supporting Document)

Comments: Two of the prior items from the July 24, 2013 objections have not been addressed, even though the response says they have.

1. The SERFF policy form IFD-PPO-POL-0113TN has the correct policy form label ONLY on the first page, not the subsequent pages. Please fix the labels for Pages 2 and later. Page 2 also says Group PPO Pediatric Dental Policy, even though the policy is an individual policy; please remedy.

2. The SERFF policy form IFD-PPO-POL-0113TN policy language still contains, in PART 6, in the section titled Termination of Policy, the language, We may terminate this Policy at any time following the first renewal date by giving the Policyholder written notice at least sixty (60) days in advance. Such language indicates optional renewability, notwithstanding a statement on Page 2 of the policy form that We cannot cancel this Policy while it is in force. Please remedy.

### **Conclusion:**

It is unlawful, in accordance with Section 56-26-102, T.C.A. for you to utilize these forms and/or rates in Tennessee until you receive approval. This is a notice of disapproval. Your filing will be held in suspense for one hundred and twenty (120) days. If no response is received from you within this time period, your filing will be considered "disapproved" for the above stated reasons.

Sincerely,

Art Lucker

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**State:** Tennessee **Filing Company:** BEST Life and Health Insurance Company  
**TOI/Sub-TOI:** H10I Individual Health - Dental/H10I.000 Health - Dental  
**Product Name:** Stand Alone Dental - Individual Market  
**Project Name/Number:** Form Filing/Exchange Products

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## Objection Letter

Objection Letter Status	Pending Company Response
Objection Letter Date	07/30/2013
Submitted Date	07/30/2013
Respond By Date	

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Dear Paul Peatross,

### **Introduction:**

I have reviewed your filing and conclude the above referenced submission cannot be approved for use in the State of Tennessee for the following reasons:

### **Objection 1**

- Individual Market Family or Child Dental Policy, IFD-PPO-POL-0113TN (Form)

Comments: Please remove the red line from this document.

### **Objection 2**

- Individual Market Family or Child Dental Policy, IFD-PPO-POL-0113TN (Form)

Comments: A plan is required to cover EHB is expected to offer benefits substantially equal to those pediatric oral benefits offered by the EHB-benchmark plan

The Benchmark plan for dental has no cost sharing on Class I services. After discussion with the acting Assistant Commissioner, she agrees that a plan that has cost sharing on the Class I services is not substantially equal to the benchmark plan.

Your schedule includes preventive services as being subject to the deductible for in network services.

### **Conclusion:**

PLEASE NOTE: The reviewer on this filing is Victoria Stotzer, if you have any questions please call her at (615) 741-6259 or through e-mail at [victoria.stotzer@tn.gov](mailto:victoria.stotzer@tn.gov).

It is unlawful, in accordance with Section 56-26-102, T.C.A. for you to utilize these forms and/or rates in Tennessee until you receive approval. This is a notice of disapproval. Your filing will be held in suspense for one hundred and twenty (120) days. If no response is received from you within this time period, your filing will be considered "disapproved" for the above stated reasons.

Sincerely,

Vicky Stotzer

**State:** Tennessee  
**TOI/Sub-TOI:** H101 Individual Health - Dental/H101.000 Health - Dental  
**Product Name:** Stand Alone Dental - Individual Market  
**Project Name/Number:** Form Filing/Exchange Products

**Filing Company:** BEST Life and Health Insurance Company

## Objection Letter

Objection Letter Status	Pending Company Response
Objection Letter Date	07/24/2013
Submitted Date	07/24/2013
Respond By Date	07/26/2013

Dear Paul Peatross,

### Introduction:

I have reviewed your filing and conclude the above referenced submission cannot be approved for use in the State of Tennessee for the following reasons:

### Objection 1

- Response to Objections to Rates (Supporting Document)

Comments: Thank you for your response. Original items 1 and 3 have not been addressed, and there is one new item, as follows:

1. (Original 1.) A modified actuarial memorandum to reflect the change from using GAD and GPD policy forms to just IFD policy forms; such memorandum should also contain relevant items below; provide modified rates if the rate structure was affected by the above change. Although modified rates have been provided as part of the actuarial material, it appears that the Rate Data Template in the ACA binder for this submission, and possibly the Rating Business Rules Template or other material, have not been updated for changes made since the original filing.
2. (Original 3.) Revision to the labeling for all but the first page of policy form IFD-PPO-POL-0113TN; the pages in question are labeled GAD-PPO-POL-0113TN, and some include reference to Group PPO Pediatric Dental Policy. Although the response to this item says Revised, the policy form does not appear to have been changed. The first page has the correct policy form number, but the subsequent pages still have the GAD label, and page 2 still has the group reference.
3. The renewability provision: non-cancellable or guaranteed renewable; the policy language appears to provide optional renewability, which is not allowed by the ACA (PHSA 2703.) Policy form IFD-PPO-POL-0113TN contains, in PART 6, in the section titled Termination of Policy, the language, We may terminate this Policy at any time following the first renewal date by giving the Policyholder written notice at least sixty (60) days in advance. Such language indicates optional renewability, notwithstanding a statement on page 2 of the policy form that We cannot cancel this Policy while it is in force. I think the intent is to be conditionally renewable, which is guaranteed renewable except for the reasons outlined in the ACA, such as non-payment of premium, fraud, market exit, etc. Note that the term non-cancelable means premiums cannot be increased, whereas the policy allows changes per PART 6.

### Conclusion:

PLEASE NOTE: The reviewer on this filing is Victoria Stotzer, if you have any questions please call her at (615) 741-6259 or through e-mail at [victoria.stotzer@tn.gov](mailto:victoria.stotzer@tn.gov).

It is unlawful, in accordance with Section 56-26-102, T.C.A. for you to utilize these forms and/or rates in Tennessee until you receive approval. This is a notice of disapproval. Your filing will be held in suspense for one hundred and twenty (120) days. If no response is received from you within this time period, your filing will be considered "disapproved" for the above stated reasons.

Sincerely,  
Art Lucker

**State:** Tennessee **Filing Company:** BEST Life and Health Insurance Company  
**TOI/Sub-TOI:** H101 Individual Health - Dental/H101.000 Health - Dental  
**Product Name:** Stand Alone Dental - Individual Market  
**Project Name/Number:** Form Filing/Exchange Products

## Objection Letter

Objection Letter Status	Pending Company Response
Objection Letter Date	07/12/2013
Submitted Date	07/12/2013
Respond By Date	07/18/2013

Dear Paul Peatross,

### **Introduction:**

I have reviewed your filing and conclude the above referenced submission cannot be approved for use in the State of Tennessee for the following reasons:

### **Objection 1**

- ACTUARIAL MEMORANDUM, [GPD-IM-PPO-POL-0113TN, GAD-IM-PPO-POL-0113TN] (Rate)

Comments: Please provide the following:

1. A modified actuarial memorandum to reflect the change from using GAD and GPD policy forms to just IFD policy forms; such memorandum should also contain relevant items below; provide modified rates if the rate structure was affected by the above change.
2. A discussion of compliance with the ACA and State regulations regarding rates and benefits. Please cite the appropriate regulations.
3. Revision to the labeling for all but the first page of policy form IFD-PPO-POL-0113TN; the pages in question are labeled GAD-PPO-POL-0113TN, and some include reference to Group PPO Pediatric Dental Policy.
4. The California claims experience referred to in the actuarial memorandum.
5. Supporting documentation for the trend rate of 4%.
6. A discussion of the model used (including methodology) to produce the AVs for high and low plans.
7. Explanation of why the Net Costs shown in the rate calculations do not agree with the values obtained by multiplying the Base Costs by the Trend and by the Area factor.
8. The assumptions, and relevant support, used to arrive at the Supplemental tiered rates from the Net Cost and Target Loss Ratio.
9. Supporting documentation for the Base Costs shown in the rate calculations.
10. Related to 2. above, please explain or correct what appears to be a non-compliant provision with respect to the ACA benefit requirements; for pediatric medically necessary orthodontia, the 24 month waiting period appears to amount to the imposition of a pre-existing condition exclusion.

### **Conclusion:**

PLEASE NOTE: The reviewer on this filing is Victoria Stotzer, if you have any questions please call her at (615) 741-6259 or through e-mail at [victoria.stotzer@tn.gov](mailto:victoria.stotzer@tn.gov).

It is unlawful, in accordance with Section 56-26-102, T.C.A. for you to utilize these forms and/or rates in Tennessee until you receive

**State:** Tennessee **Filing Company:** BEST Life and Health Insurance Company  
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approval. This is a notice of disapproval. Your filing will be held in suspense for one hundred and twenty (120) days. If no response is received from you within this time period, your filing will be considered "disapproved" for the above stated reasons.

Sincerely,

Art Lucker

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<b>State:</b>	Tennessee	<b>Filing Company:</b>	BEST Life and Health Insurance Company
<b>TOI/Sub-TOI:</b>	H101 Individual Health - Dental/H101.000 Health - Dental		
<b>Product Name:</b>	Stand Alone Dental - Individual Market		
<b>Project Name/Number:</b>	Form Filing/Exchange Products		

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## Objection Letter

Objection Letter Status	Pending Company Response
Objection Letter Date	05/31/2013
Submitted Date	05/31/2013
Respond By Date	

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Dear Paul Peatross,

### **Introduction:**

I have reviewed your filing and conclude the above referenced submission cannot be approved for use in the State of Tennessee for the following reasons:

### **Objection 1**

- Individual Market Pediatric Dental Certificate, GPD-IM-PPO-CERT-0113TN (Form)

Comments: (12) Expenses incurred for gingivectomy or gingivoplasty, periodontal scaling and root planning, full mouth debridement, and periodontal maintenance;

These services are covered in the FEDVIP.

### **Objection 2**

Comments: (21) Services not completed on or before the date of termination;

You need to allow at least 30 days to complete a procedure started while covered under the contract.

### **Objection 3**

Comments: Although the policy is issued in California, we do regulate the product so stating California has jurisdiction is not accurate.

### **Objection 4**

Comments: The Policy is the contract between BEST Life and the Policyholder named on the Schedule of Benefits. The Policy may be changed or ended without the consent of or notice to the Certificate holder.

Please place notice on the face page of the certificate that this coverage is optionally renewable and may be cancelled by the company.

You can terminate without consent but you must provide notice. This is marketed to the individual.

### **Objection 5**

- Individual Market Adult Dental Certificate, GAD-IM-PPO-CERT-0113TN (Form)

Comments: We are currently awaiting an opinion from our legal area as to whether or not you can cover only dependents between ages 20 and 26. Our newborn law has a guaranteed issue requirement.

### **Objection 6**

- Individual Market Pediatric Dental Certificate, GPD-IM-PPO-CERT-0113TN (Form)

Comments: Isn't the dental subject to the same grace period restrictions when sold on the exchange?

### **Conclusion:**

It is unlawful, in accordance with Section 56-26-102, T.C.A. for you to utilize these forms and/or rates in Tennessee until you receive approval. This is a notice of disapproval. Your filing will be held in suspense for one hundred and twenty (120) days. If no response is received from you within this time period, your filing will be considered "disapproved" for the above stated reasons. If you have any questions, please phone Victoria Stotzer, primary reviewer, at (615) 741-6259 or through e-mail at [victoria.stotzer@tn.gov](mailto:victoria.stotzer@tn.gov).



**State:** Tennessee **Filing Company:** BEST Life and Health Insurance Company  
**TOI/Sub-TOI:** H10I Individual Health - Dental/H10I.000 Health - Dental  
**Product Name:** Stand Alone Dental - Individual Market  
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questions, please phone Victoria Stotzer, primary reviewer, at (615) 741-6259 or through e-mail at [victoria.stotzer@tn.gov](mailto:victoria.stotzer@tn.gov).

Sincerely,

Melissa Merritt

<b>State:</b>	Tennessee	<b>Filing Company:</b>	BEST Life and Health Insurance Company
<b>TOI/Sub-TOI:</b>	H10I Individual Health - Dental/H10I.000 Health - Dental		
<b>Product Name:</b>	Stand Alone Dental - Individual Market		
<b>Project Name/Number:</b>	Form Filing/Exchange Products		

## Response Letter

Response Letter Status	Submitted to State
Response Letter Date	08/09/2013
Submitted Date	08/09/2013

*Dear Vicky Stotzer,*

### **Introduction:**

### **Response 1**

#### **Comments:**

*Forms have been updated per the telephone direction.*

### **Related Objection 1**

*Comments: I am not sure what the change you made meets the request.*

*You need to waive the deductible for preventive services in the high option plan. The original deductibles may remain the same.*

*This change must be made in the policy and the certificate.*

### **Changed Items:**

*No Supporting Documents changed.*

State: Tennessee Filing Company: BEST Life and Health Insurance Company  
 TOI/Sub-TOI: H10I Individual Health - Dental/H10I.000 Health - Dental  
 Product Name: Stand Alone Dental - Individual Market  
 Project Name/Number: Form Filing/Exchange Products

Form Schedule Item Changes								
Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Individual Market Pediatric Dental Group Policy	IFD-PPO-POL-0113TN	POL	Initial		43.500	IFD-PPO-POL-0113TN(3).pdf	Date Submitted: 08/09/2013 By: Paul Peatross
Previous Version								
1	Individual Market Pediatric Dental Group Policy	IFD-PPO-POL-0113TN	POL	Initial		43.500	IFD-PPO-POL-0113TN(3).pdf	Date Submitted: 07/31/2013 By: Paul Peatross
Previous Version								
1	Individual Market Pediatric Dental Group Policy		POL	Initial		43.500		Date Submitted: 06/13/2013 By: Margie Mergen
Previous Version								
1	Individual Market Pediatric Dental Group Policy	GPD-IM-PPO-POL-0113TN	POL	Initial			GPD-IM-PPO-POL-0113TN.pdf	Date Submitted: 04/30/2013 By: Margie Mergen
2	Individual Market Family or Child Outline of Coverage	IFD-PPO-OC-0113TN	OUT	Initial			IFD-PPO-OC-0113TN(3).pdf	Date Submitted: 08/09/2013 By: Paul Peatross
Previous Version								
2	Individual Market Family or Child Outline of Coverage	IFD-PPO-OC-0113TN	OUT	Initial			IFD-PPO-OC-0113TN.pdf	Date Submitted: 06/13/2013 By: Margie Mergen

<b>State:</b>	Tennessee	<b>Filing Company:</b>	BEST Life and Health Insurance Company
<b>TOI/Sub-TOI:</b>	H10I Individual Health - Dental/H10I.000 Health - Dental		
<b>Product Name:</b>	Stand Alone Dental - Individual Market		
<b>Project Name/Number:</b>	Form Filing/Exchange Products		

Form Schedule Item Changes								
Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Individual Market Pediatric Dental Group Policy	IFD-PPO-POL-0113TN	POL	Initial		43.500	IFD-PPO-POL-0113TN(3).pdf	Date Submitted: 08/09/2013 By: Paul Peatross
<i>Previous Version</i>								
2	Individual Market Adult Dental Certificate	GAD-IM-PPO-CERT-0113TN	CER	Initial		43.500	GAD-IM-PPO-CERT-0113TN.pdf	Date Submitted: 04/30/2013 By: Margie Mergen

No Rate/Rule Schedule items changed.

**Conclusion:**

Sincerely,  
Paul Peatross

State:	Tennessee	Filing Company:	BEST Life and Health Insurance Company
TOI/Sub-TOI:	H10I Individual Health - Dental/H10I.000 Health - Dental		
Product Name:	Stand Alone Dental - Individual Market		
Project Name/Number:	Form Filing/Exchange Products		

## Response Letter

Response Letter Status	Submitted to State
Response Letter Date	07/31/2013
Submitted Date	07/31/2013

Dear Vicky Stotzer,

### Introduction:

BEST Life has reviewed this objection and responds as follows:

### Response 1

#### Comments:

The modified form is attached.

### Related Objection 1

Applies To:

- Response to Objections to Rates (Supporting Document)

Comments: Two of the prior items from the July 24, 2013 objections have not been addressed, even though the response says they have.

1. The SERFF policy form IFD-PPO-POL-0113TN has the correct policy form label ONLY on the first page, not the subsequent pages. Please fix the labels for Pages 2 and later. Page 2 also says Group PPO Pediatric Dental Policy, even though the policy is an individual policy; please remedy.

2. The SERFF policy form IFD-PPO-POL-0113TN policy language still contains, in PART 6, in the section titled Termination of Policy, the language, We may terminate this Policy at any time following the first renewal date by giving the Policyholder written notice at least sixty (60) days in advance. Such language indicates optional renewability, notwithstanding a statement on Page 2 of the policy form that We cannot cancel this Policy while it is in force. Please remedy.

### Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	redline
Comments:	
Attachment(s):	IFD-PPO-POL-0113TN(2)-redline.pdf

State: Tennessee Filing Company: BEST Life and Health Insurance Company  
 TOI/Sub-TOI: H10I Individual Health - Dental/H10I.000 Health - Dental  
 Product Name: Stand Alone Dental - Individual Market  
 Project Name/Number: Form Filing/Exchange Products

Form Schedule Item Changes								
Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Individual Market Family or Child Dental Policy	IFD-PPO-POL-0113TN	POL	Initial		43.500	IFD-PPO-POL-0113TN.pdf, IFD-PPO-POL-0113TN_redline.pdf	Date Submitted: 07/31/2013 By: Paul Peatross
Previous Version								
1	Individual Market Family or Child Dental Policy	IFD-PPO-POL-0113TN	POL	Initial		43.500	GAD-IM-PPO-POL-0113TN_redline.pdf, IFD-PPO-POL-0113TN.pdf	Date Submitted: 06/13/2013 By: Margie Mergen
Previous Version								
1	Individual Market Adult Dental Policy	GAD-IM-PPO-POL-0113TN	POL	Initial			GAD-IM-PPO-POL-0113TN.pdf	Date Submitted: 04/30/2013 By: Margie Mergen

No Rate/Rule Schedule items changed.

**Conclusion:**

Thank you for your review.

Sincerely,

Paul Peatross

State:	Tennessee	Filing Company:	BEST Life and Health Insurance Company
TOI/Sub-TOI:	H10I Individual Health - Dental/H10I.000 Health - Dental		
Product Name:	Stand Alone Dental - Individual Market		
Project Name/Number:	Form Filing/Exchange Products		

## Response Letter

Response Letter Status	Submitted to State
Response Letter Date	07/31/2013
Submitted Date	07/31/2013

Dear Vicky Stotzer,

### Introduction:

BEST Life has reviewed the department's objections to it filing and responds as follows:

### Response 1

#### Comments:

The redline was removed to supporting documents.

### Related Objection 1

Applies To:

- Individual Market Family or Child Dental Policy, IFD-PPO-POL-0113TN (Form)

Comments: Please remove the red line from this document.

### Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	redline
Comments:	
Attachment(s):	IFD-PPO-POL-0113TN(3)-redline.pdf
Previous Version	
Satisfied - Item:	redline
Comments:	
Attachment(s):	IFD-PPO-POL-0113TN(2)-redline.pdf

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

State:	Tennessee	Filing Company:	BEST Life and Health Insurance Company
TOI/Sub-TOI:	H10I Individual Health - Dental/H10I.000 Health - Dental		
Product Name:	Stand Alone Dental - Individual Market		
Project Name/Number:	Form Filing/Exchange Products		

## Response 2

### Comments:

The cost sharing was removed from the pediatric oral benefits. This created a change to the rest of the in network benefits and the out of network deductible to support the required actuarial value and reasonableness.

## Related Objection 2

Applies To:

- Individual Market Family or Child Dental Policy, IFD-PPO-POL-0113TN (Form)

Comments: A plan is required to cover EHB is expected to offer benefits substantially equal to those pediatric oral benefits offered by the EHB-benchmark plan

The Benchmark plan for dental has no cost sharing on Class I services. After discussion with the acting Assistant Commissioner, she agrees that a plan that has cost sharing on the Class I services is not substantially equal to the benchmark plan.

Your schedule includes preventive services as being subject to the deductible for in network services.

## Changed Items:

No Supporting Documents changed.



State: Tennessee Filing Company: BEST Life and Health Insurance Company  
 TOI/Sub-TOI: H10I Individual Health - Dental/H10I.000 Health - Dental  
 Product Name: Stand Alone Dental - Individual Market  
 Project Name/Number: Form Filing/Exchange Products

Form Schedule Item Changes								
Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Individual Market Pediatric Dental Group Policy	IFD-PPO-POL-0113TN	POL	Initial		43.500	IFD-PPO-POL-0113TN(3).pdf	Date Submitted: 07/31/2013 By: Paul Peatross
Previous Version								
1	Individual Market Pediatric Dental Group Policy		POL	Initial		43.500		Date Submitted: 06/13/2013 By: Margie Mergen
Previous Version								
1	Individual Market Pediatric Dental Group Policy	GPD-IM-PPO-POL-0113TN	POL	Initial			GPD-IM-PPO-POL-0113TN.pdf	Date Submitted: 04/30/2013 By: Margie Mergen

No Rate/Rule Schedule items changed.

**Conclusion:**

Thank you for your review of this filing.

Sincerely,

Paul Peatross

State:	Tennessee	Filing Company:	BEST Life and Health Insurance Company
TOI/Sub-TOI:	H10I Individual Health - Dental/H10I.000 Health - Dental		
Product Name:	Stand Alone Dental - Individual Market		
Project Name/Number:	Form Filing/Exchange Products		

## Response Letter

Response Letter Status	Submitted to State
Response Letter Date	07/26/2013
Submitted Date	07/26/2013

Dear Vicky Stotzer,

### Introduction:

### Response 1

#### Comments:

Done.

### Related Objection 1

Applies To:

- Response to Objections to Rates (Supporting Document)

Comments: Thank you for your response. Original items 1 and 3 have not been addressed, and there is one new item, as follows:

1. (Original 1.) A modified actuarial memorandum to reflect the change from using GAD and GPD policy forms to just IFD policy forms; such memorandum should also contain relevant items below; provide modified rates if the rate structure was affected by the above change. Although modified rates have been provided as part of the actuarial material, it appears that the Rate Data Template in the ACA binder for this submission, and possibly the Rating Business Rules Template or other material, have not been updated for changes made since the original filing.

2. (Original 3.) Revision to the labeling for all but the first page of policy form IFD-PPO-POL-0113TN; the pages in question are labeled GAD-PPO-POL-0113TN, and some include reference to Group PPO Pediatric Dental Policy. Although the response to this item says Revised, the policy form does not appear to have been changed. The first page has the correct policy form number, but the subsequent pages still have the GAD label, and page 2 still has the group reference.

3. The renewability provision: non-cancellable or guaranteed renewable; the policy language appears to provide optional renewability, which is not allowed by the ACA (PHSA 2703.) Policy form IFD-PPO-POL-0113TN contains, in PART 6, in the section titled Termination of Policy, the language, We may terminate this Policy at any time following the first renewal date by giving the Policyholder written notice at least sixty (60) days in advance. Such language indicates optional renewability, notwithstanding a statement on page 2 of the policy form that We cannot cancel this Policy while it is in force. I think the intent is to be conditionally renewable, which is guaranteed renewable except for the reasons outlined in the ACA, such as non-payment of premium, fraud, market exit, etc. Note that the term non-cancelable means premiums cannot be increased, whereas the policy allows changes per PART 6.

### Changed Items:

<b>State:</b>	Tennessee	<b>Filing Company:</b>	BEST Life and Health Insurance Company
<b>TOI/Sub-TOI:</b>	H10I Individual Health - Dental/H10I.000 Health - Dental		
<b>Product Name:</b>	Stand Alone Dental - Individual Market		
<b>Project Name/Number:</b>	Form Filing/Exchange Products		

Supporting Document Schedule Item Changes	
<b>Satisfied - Item:</b>	Response to Objections to Rates
<b>Comments:</b>	
<b>Attachment(s):</b>	Determination of Age Factors.pdf Summary of Area Factors - TN 06242013.pdf Summary of Normalized Paid to Children 0-19.xlsx PM_FAQ10v2_508cr_052313.pdf Actuarial Memorandum TN - Individual July 18 2013.pdf
<i>Previous Version</i>	
<b>Satisfied - Item:</b>	<i>Response to Objections to Rates</i>
<b>Comments:</b>	
<b>Attachment(s):</b>	<i>Determination of Age Factors.pdf</i> <i>Summary of Area Factors - TN 06242013.pdf</i> <i>Summary of Normalized Paid to Children 0-19.xlsx</i> <i>PM_FAQ10v2_508cr_052313.pdf</i>

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

**Conclusion:**

Sincerely,  
Margie Mergen

State:	Tennessee	Filing Company:	BEST Life and Health Insurance Company
TOI/Sub-TOI:	H10I Individual Health - Dental/H10I.000 Health - Dental		
Product Name:	Stand Alone Dental - Individual Market		
Project Name/Number:	Form Filing/Exchange Products		

## Response Letter

Response Letter Status	Submitted to State
Response Letter Date	07/18/2013
Submitted Date	07/18/2013

Dear Vicky Stotzer,

### Introduction:

### Response 1

#### Comments:

We are enclosed updated actuarial memo and rates and exhibits. We will do a search and look for "Group PPO Pediatric Dental Policy". Should have these for you by tomorrow.

The 24 month wait is not an exclusion. Our policy does not exclude it. Please see the FAQs provided from CMS. Page 2, highlighted text states that this is permissible.

### Related Objection 1

Applies To:

- ACTUARIAL MEMORANDUM, [GPD-IM-PPO-POL-0113TN, GAD-IM-PPO-POL-0113TN] (Rate)

<b>State:</b>	Tennessee	<b>Filing Company:</b>	BEST Life and Health Insurance Company
<b>TOI/Sub-TOI:</b>	H10I Individual Health - Dental/H10I.000 Health - Dental		
<b>Product Name:</b>	Stand Alone Dental - Individual Market		
<b>Project Name/Number:</b>	Form Filing/Exchange Products		

Comments: Please provide the following:

1. A modified actuarial memorandum to reflect the change from using GAD and GPD policy forms to just IFD policy forms; such memorandum should also contain relevant items below; provide modified rates if the rate structure was affected by the above change.
2. A discussion of compliance with the ACA and State regulations regarding rates and benefits. Please cite the appropriate regulations.
3. Revision to the labeling for all but the first page of policy form IFD-PPO-POL-0113TN; the pages in question are labeled GAD-PPO-POL-0113TN, and some include reference to Group PPO Pediatric Dental Policy.
4. The California claims experience referred to in the actuarial memorandum.
5. Supporting documentation for the trend rate of 4%.
6. A discussion of the model used (including methodology) to produce the AVs for high and low plans.
7. Explanation of why the Net Costs shown in the rate calculations do not agree with the values obtained by multiplying the Base Costs by the Trend and by the Area factor.
8. The assumptions, and relevant support, used to arrive at the Supplemental tiered rates from the Net Cost and Target Loss Ratio.
9. Supporting documentation for the Base Costs shown in the rate calculations.
10. Related to 2. above, please explain or correct what appears to be a non-compliant provision with respect to the ACA benefit requirements; for pediatric medically necessary orthodontia, the 24 month waiting period appears to amount to the imposition of a pre-existing condition exclusion.

**Changed Items:**

Supporting Document Schedule Item Changes	
<b>Satisfied - Item:</b>	Response to Objections to Rates
<b>Comments:</b>	
<b>Attachment(s):</b>	Determination of Age Factors.pdf Summary of Area Factors - TN 06242013.pdf Summary of Normalized Paid to Children 0-19.xlsx PM_FAQ10v2_508cr_052313.pdf

State: Tennessee Filing Company: BEST Life and Health Insurance Company  
 TOI/Sub-TOI: H10I Individual Health - Dental/H10I.000 Health - Dental  
 Product Name: Stand Alone Dental - Individual Market  
 Project Name/Number: Form Filing/Exchange Products

No Form Schedule items changed.

Rate/Rule Schedule Item Changes						
Item No.	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments	Date Submitted
1	ACTUARIAL MEMORANDUM	IFD-PPO-POL-0113TN	New		Actuarial Memorandum TN - Individual July 18 2013.pdf,	07/18/2013 By: Margie Mergen
<i>Previous Version</i>						
1	ACTUARIAL MEMORANDUM	GPD-IM-PPO-POL-0113TN, GAD-IM-PPO-POL-0113TN	New		Actuarial Memorandum TN - Individual April 30 2013.pdf,	04/30/2013 By: Margie Mergen
2	PEDIATRIC RATE CALCULATIONS	IFD-PPO-POL-0113TN	New		Individual Pediatric Rates - TN 06242013.pdf,	07/18/2013 By: Margie Mergen
<i>Previous Version</i>						
2	PEDIATRIC RATE CALCULATIONS	GPD-IM-PPO-POL-0113TN	New		Individual Pediatric - TN 04302013.pdf,	04/30/2013 By: Margie Mergen
3	ADULT RATE CALCULATIONS	IFD-PPO-POL-0113TN	New		Individual Supplemental Rates - TN 06242013.pdf,	07/18/2013 By: Margie Mergen
<i>Previous Version</i>						
3	ADULT RATE CALCULATIONS	GAD-IM-PPO-POL-0113TN	New		Individual Supplemental - TN 04302013.pdf,	04/30/2013 By: Margie Mergen

**Conclusion:**

Sincerely,

<b>SERFF Tracking #:</b>	BLHI-129004054	<b>State Tracking #:</b>	H-130559	<b>Company Tracking #:</b>	FORM FILING
<b>State:</b>	Tennessee	<b>Filing Company:</b>	BEST Life and Health Insurance Company		
<b>TOI/Sub-TOI:</b>	H10I Individual Health - Dental/H10I.000 Health - Dental				
<b>Product Name:</b>	Stand Alone Dental - Individual Market				
<b>Project Name/Number:</b>	Form Filing/Exchange Products				

Margie Mergen

State:	Tennessee	Filing Company:	BEST Life and Health Insurance Company
TOI/Sub-TOI:	H10I Individual Health - Dental/H10I.000 Health - Dental		
Product Name:	Stand Alone Dental - Individual Market		
Project Name/Number:	Form Filing/Exchange Products		

## Response Letter

Response Letter Status	Submitted to State
Response Letter Date	06/13/2013
Submitted Date	06/13/2013

Dear Vicky Stotzer,

### Introduction:

After the fact, we have learned that any policy we offer on the exchange must include the pediatric plan. Because of this, we are revising our policies as follows:

- 1) We are withdrawing the GPD-IM forms from this filing so that there is only one set of forms that can be used as a child only policy and as a family policy.
- 2) GAD-IM forms have been converted into IFD forms. F for family, I for Individual. These IFD forms are a combination of the GAD and GPD forms. Makes it simple that you now only have to review one set of forms. We included a redlined version of the GAD-IM policy so that you can see what additions we made to it to convert it into IFD. If this is too confusing, please follow the clean version of IFD.
- 3) We are removing the Association from this filing. The Individual will be the policyholder. We are withdrawing any Certificates of Insurance and are including an Outline of Coverage.

### Response 1

#### Comments:

Removed.

### Related Objection 1

Applies To:

- Individual Market Pediatric Dental Certificate, GPD-IM-PPO-CERT-0113TN (Form)

Comments: (12) Expenses incurred for gingivectomy or gingivoplasty, periodontal scaling and root planning, full mouth debridement, and periodontal maintenance;

These services are covered in the FEDVIP.

### Changed Items:

No Supporting Documents changed.



State: Tennessee Filing Company: BEST Life and Health Insurance Company  
 TOI/Sub-TOI: H10I Individual Health - Dental/H10I.000 Health - Dental  
 Product Name: Stand Alone Dental - Individual Market  
 Project Name/Number: Form Filing/Exchange Products

Form Schedule Item Changes								
Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Individual Market Pediatric Dental Certificate		CER	Initial		43.500		Date Submitted: 06/13/2013 By: Margie Mergen
Previous Version								
1	Individual Market Pediatric Dental Certificate	GPD-IM-PPO-CERT-0113TN	CER	Initial		43.500	GPD-IM-PPO-CERT-0113TN.pdf	Date Submitted: 04/30/2013 By: Margie Mergen
2	Individual Market Pediatric Dental Statement of Variability		MTX	Initial		43.500		Date Submitted: 06/13/2013 By: Margie Mergen
Previous Version								
2	Individual Market Pediatric Dental Statement of Variability	GPD-IM-PPO-SOV-0113TN	MTX	Initial			GPD-IM-PPO-SOV-0113TN.pdf	Date Submitted: 04/30/2013 By: Margie Mergen
3	Individual Market Family Dental Variability Statement	IFD-PPO-SOV-0113TN	MTX	Initial			IFD-PPO-SOV-0113TN.pdf	Date Submitted: 06/13/2013 By: Margie Mergen
Previous Version								

State: Tennessee Filing Company: BEST Life and Health Insurance Company  
 TOI/Sub-TOI: H10I Individual Health - Dental/H10I.000 Health - Dental  
 Product Name: Stand Alone Dental - Individual Market  
 Project Name/Number: Form Filing/Exchange Products

Form Schedule Item Changes								
Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Individual Market Pediatric Dental Certificate		CER	Initial		43.500		Date Submitted: 06/13/2013 By: Margie Mergen
3	Individual Market Adult Dental Variability Statement	GAD-IM-PPO-SOV-0113TN	MTX	Initial			GAD-IM-PPO-SOV-0113TN.pdf	Date Submitted: 04/30/2013 By: Margie Mergen
4	Individual Market Pediatric Dental Group Policy		POL	Initial		43.500		Date Submitted: 06/13/2013 By: Margie Mergen
Previous Version								
4	Individual Market Pediatric Dental Group Policy	GPD-IM-PPO-POL-0113TN	POL	Initial			GPD-IM-PPO-POL-0113TN.pdf	Date Submitted: 04/30/2013 By: Margie Mergen
5	Individual Market Family or Child Dental Policy	IFD-PPO-POL-0113TN	POL	Initial		43.500	GAD-IM-PPO-POL-0113TN_redline.pdf, IFD-PPO-POL-0113TN.pdf	Date Submitted: 06/13/2013 By: Margie Mergen
Previous Version								
5	Individual Market Adult Dental Policy	GAD-IM-PPO-POL-0113TN	POL	Initial			GAD-IM-PPO-POL-0113TN.pdf	Date Submitted: 04/30/2013 By: Margie Mergen

State: Tennessee Filing Company: BEST Life and Health Insurance Company  
 TOI/Sub-TOI: H10I Individual Health - Dental/H10I.000 Health - Dental  
 Product Name: Stand Alone Dental - Individual Market  
 Project Name/Number: Form Filing/Exchange Products

Form Schedule Item Changes								
Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Individual Market Pediatric Dental Certificate		CER	Initial		43.500		Date Submitted: 06/13/2013 By: Margie Mergen
6	Individual Market Family or Child Outline of Coverage	IFD-PPO-OC-0113TN	OUT	Initial			IFD-PPO-OC-0113TN.pdf	Date Submitted: 06/13/2013 By: Margie Mergen
Previous Version								
6	Individual Market Adult Dental Certificate	GAD-IM-PPO-CERT-0113TN	CER	Initial		43.500	GAD-IM-PPO-CERT-0113TN.pdf	Date Submitted: 04/30/2013 By: Margie Mergen

No Rate/Rule Schedule items changed.

## Response 2

### Comments:

Please refer us to the specific law so that we can revise this exclusion accordingly.

## Related Objection 2

Comments: (21) Services not completed on or before the date of termination;

You need to allow at least 30 days to complete a procedure started while covered under the contract.

## Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

<b>State:</b>	Tennessee	<b>Filing Company:</b>	BEST Life and Health Insurance Company
<b>TOI/Sub-TOI:</b>	H10I Individual Health - Dental/H10I.000 Health - Dental		
<b>Product Name:</b>	Stand Alone Dental - Individual Market		
<b>Project Name/Number:</b>	Form Filing/Exchange Products		

No Rate/Rule Schedule items changed.

### Response 3

#### Comments:

We have removed the Association from this filing, so now Tennessee is listed as the Jurisdiction.

### Related Objection 3

Comments: Although the policy is issued in California, we do regulate the product so stating California has jurisdiction is not accurate.

### Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes								
Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Individual Market Family or Child Dental Policy	IFD-PPO-POL-0113TN	POL	Initial		43.500	GAD-IM-PPO-POL-0113TN_redline.pdf, IFD-PPO-POL-0113TN.pdf	Date Submitted: 06/13/2013 By: Margie Mergen
Previous Version								
1	Individual Market Adult Dental Policy	GAD-IM-PPO-POL-0113TN	POL	Initial			GAD-IM-PPO-POL-0113TN.pdf	Date Submitted: 04/30/2013 By: Margie Mergen

No Rate/Rule Schedule items changed.

### Response 4

#### Comments:

This has been done.

### Related Objection 4

**State:** Tennessee  
**TOI/Sub-TOI:** H10I Individual Health - Dental/H10I.000 Health - Dental  
**Product Name:** Stand Alone Dental - Individual Market  
**Project Name/Number:** Form Filing/Exchange Products

**Filing Company:** BEST Life and Health Insurance Company

Comments: The Policy is the contract between BEST Life and the Policyholder named on the Schedule of Benefits. The Policy may be changed or ended without the consent of or notice to the Certificate holder.

Please place notice on the face page of the certificate that this coverage is optionally renewable and may be cancelled by the company. You can terminate without consent but you must provide notice. This is marketed to the individual.

**Changed Items:**

No Supporting Documents changed.

Form Schedule Item Changes								
Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Individual Market Family or Child Dental Policy	IFD-PPO-POL-0113TN	POL	Initial		43.500	GAD-IM-PPO-POL-0113TN_redline.pdf, IFD-PPO-POL-0113TN.pdf	Date Submitted: 06/13/2013 By: Margie Mergen
Previous Version								
1	Individual Market Adult Dental Policy	GAD-IM-PPO-POL-0113TN	POL	Initial			GAD-IM-PPO-POL-0113TN.pdf	Date Submitted: 04/30/2013 By: Margie Mergen

No Rate/Rule Schedule items changed.

**Response 5**

**Comments:**

Please refer to how we define Child under the Definitions section. This should clear up any confusion on how we intend to cover eligible dependent children.

**Related Objection 5**

Applies To:

- Individual Market Adult Dental Certificate, GAD-IM-PPO-CERT-0113TN (Form)

Comments: We are currently awaiting an opinion from our legal area as to whether or not you can cover only dependents between ages 20 and 26. Our newborn law has a guaranteed issue requirement.

State: Tennessee Filing Company: BEST Life and Health Insurance Company  
 TOI/Sub-TOI: H10I Individual Health - Dental/H10I.000 Health - Dental  
 Product Name: Stand Alone Dental - Individual Market  
 Project Name/Number: Form Filing/Exchange Products

**Changed Items:**

No Supporting Documents changed.

Form Schedule Item Changes								
Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Individual Market Family or Child Outline of Coverage	IFD-PPO-OC-0113TN	OUT	Initial			IFD-PPO-OC-0113TN.pdf	Date Submitted: 06/13/2013 By: Margie Mergen
Previous Version								
1	Individual Market Adult Dental Certificate	GAD-IM-PPO-CERT-0113TN	CER	Initial		43.500	GAD-IM-PPO-CERT-0113TN.pdf	Date Submitted: 04/30/2013 By: Margie Mergen

No Rate/Rule Schedule items changed.

**Response 6**

**Comments:**

Please advise. Any guidance will help take out the guess work and be greatly appreciated. Thank you.

**Related Objection 6**

Applies To:

- Individual Market Pediatric Dental Certificate, GPD-IM-PPO-CERT-0113TN (Form)

Comments: Isn't the dental subject to the same grace period restrictions when sold on the exchange?

**Changed Items:**

No Supporting Documents changed.

State: Tennessee Filing Company: BEST Life and Health Insurance Company  
 TOI/Sub-TOI: H10I Individual Health - Dental/H10I.000 Health - Dental  
 Product Name: Stand Alone Dental - Individual Market  
 Project Name/Number: Form Filing/Exchange Products

Form Schedule Item Changes								
Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Individual Market Pediatric Dental Certificate		CER	Initial		43.500		Date Submitted: 06/13/2013 By: Margie Mergen
Previous Version								
1	Individual Market Pediatric Dental Certificate	GPD-IM-PPO-CERT-0113TN	CER	Initial		43.500	GPD-IM-PPO-CERT-0113TN.pdf	Date Submitted: 04/30/2013 By: Margie Mergen
2	Individual Market Family or Child Dental Policy	IFD-PPO-POL-0113TN	POL	Initial		43.500	GAD-IM-PPO-POL-0113TN_redline.pdf, IFD-PPO-POL-0113TN.pdf	Date Submitted: 06/13/2013 By: Margie Mergen
Previous Version								
2	Individual Market Adult Dental Policy	GAD-IM-PPO-POL-0113TN	POL	Initial			GAD-IM-PPO-POL-0113TN.pdf	Date Submitted: 04/30/2013 By: Margie Mergen

No Rate/Rule Schedule items changed.

**Conclusion:**

Sincerely,  
Margie Mergen

**State:** Tennessee **Filing Company:** BEST Life and Health Insurance Company  
**TOI/Sub-TOI:** H10I Individual Health - Dental/H10I.000 Health - Dental  
**Product Name:** Stand Alone Dental - Individual Market  
**Project Name/Number:** Form Filing/Exchange Products

## Note To Filer

**Created By:**

Brian Hoffmeister on 08/01/2013 01:12 PM

**Last Edited By:**

Brian Hoffmeister

**Submitted On:**

08/01/2013 01:12 PM

**Subject:**

Deadline Has Passed

**Comments:**

Our deadline of July 31, 2013 for approval of forms and rates for use on the FFM in Tennessee has passed. As this filing was not approved prior to the deadline, these plans will not be available on the FFM in Tennessee. If you have any questions, please do not hesitate to contact me.

Brian K. Hoffmeister  
Director, Policy Analysis Section  
Davy Crockett Tower 6th floor  
500 James Robertson Pkwy  
Nashville, TN 37243  
Phone: 615-741-5602  
Fax: 615-741-0648



**State:** Tennessee **Filing Company:** BEST Life and Health Insurance Company  
**TOI/Sub-TOI:** H10I Individual Health - Dental/H10I.000 Health - Dental  
**Product Name:** Stand Alone Dental - Individual Market  
**Project Name/Number:** Form Filing/Exchange Products

## Note To Filer

**Created By:**

Vicky Stotzer on 07/31/2013 05:39 PM

**Last Edited By:**

Vicky Stotzer

**Submitted On:**

07/31/2013 05:40 PM

**Subject:**

HIOS

**Comments:**

I imagine they will make an exception.

**State:** Tennessee **Filing Company:** BEST Life and Health Insurance Company  
**TOI/Sub-TOI:** H10I Individual Health - Dental/H10I.000 Health - Dental  
**Product Name:** Stand Alone Dental - Individual Market  
**Project Name/Number:** Form Filing/Exchange Products

## Note To Reviewer

**Created By:**

Paul Peatross on 07/31/2013 04:45 PM

**Last Edited By:**

Paul Peatross

**Submitted On:**

07/31/2013 04:45 PM

**Subject:**

HIOS and SERFF

**Comments:**

The templates in HIOS and SERFF are not validating. The forms are uploaded but the rates and templates can not be updated.

**State:** Tennessee **Filing Company:** BEST Life and Health Insurance Company  
**TOI/Sub-TOI:** H10I Individual Health - Dental/H10I.000 Health - Dental  
**Product Name:** Stand Alone Dental - Individual Market  
**Project Name/Number:** Form Filing/Exchange Products

## Note To Filer

**Created By:**

Vicky Stotzer on 07/31/2013 01:44 PM

**Last Edited By:**

Vicky Stotzer

**Submitted On:**

07/31/2013 01:44 PM

**Subject:**

Forms

**Comments:**

Okay. The actuary has signed off on both filings.

Vicky

**State:** Tennessee **Filing Company:** BEST Life and Health Insurance Company  
**TOI/Sub-TOI:** H10I Individual Health - Dental/H10I.000 Health - Dental  
**Product Name:** Stand Alone Dental - Individual Market  
**Project Name/Number:** Form Filing/Exchange Products

## Note To Reviewer

**Created By:**

Paul Peatross on 07/31/2013 01:31 PM

**Last Edited By:**

Paul Peatross

**Submitted On:**

07/31/2013 01:31 PM

**Subject:**

Forms

**Comments:**

These forms are being updated at this moment. They should be available on SERFF within 45 minutes.

**State:** Tennessee **Filing Company:** BEST Life and Health Insurance Company  
**TOI/Sub-TOI:** H10I Individual Health - Dental/H10I.000 Health - Dental  
**Product Name:** Stand Alone Dental - Individual Market  
**Project Name/Number:** Form Filing/Exchange Products

## Note To Filer

**Created By:**

Vicky Stotzer on 07/31/2013 08:58 AM

**Last Edited By:**

Vicky Stotzer

**Submitted On:**

07/31/2013 08:58 AM

**Subject:**

Time Limit

**Comments:**

You need to respond to these letters by 12:00 CM time today.

Vicky

**State:** Tennessee **Filing Company:** BEST Life and Health Insurance Company  
**TOI/Sub-TOI:** H10I Individual Health - Dental/H10I.000 Health - Dental  
**Product Name:** Stand Alone Dental - Individual Market  
**Project Name/Number:** Form Filing/Exchange Products

## Note To Filer

**Created By:**

Vicky Stotzer on 07/30/2013 10:06 AM

**Last Edited By:**

Vicky Stotzer

**Submitted On:**

07/30/2013 10:06 AM

**Subject:**

Note regarding last objection

**Comments:**

The no cost sharing requirement is regarding the high plan. The low plan can have minor cost sharing to reduce the AV.  
Vicky

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<b>State:</b>	Tennessee	<b>Filing Company:</b>	BEST Life and Health Insurance Company
<b>TOI/Sub-TOI:</b>	H10I Individual Health - Dental/H10I.000 Health - Dental		
<b>Product Name:</b>	Stand Alone Dental - Individual Market		
<b>Project Name/Number:</b>	Form Filing/Exchange Products		

## Note To Filer

**Created By:**

Brian Hoffmeister on 07/17/2013 02:48 PM

**Last Edited By:**

Brian Hoffmeister

**Submitted On:**

07/17/2013 02:48 PM

**Subject:**

Response Needed

**Comments:**

The approval deadline for this filing is July 31, 2013 since this filing is for plans that will be offered on the FFM in Tennessee. As of today, we have not received a response to our letter citing deficiencies in the filing. In order to meet the July 31st deadline set by HHS, we need to have your response no later than July 24, 2013. This will allow us time to review your response and ask for any additional corrections before the approval deadline.

If you have any questions, please contact Vicky Stotzer at 615-741-6259 or Victoria.stotzer@tn.gov.

Brian K. Hoffmeister  
Director, Policy Analysis Section  
Davy Crockett Tower 6th floor  
500 James Robertson Pkwy  
Nashville, TN 37243  
Phone: 615-741-5602  
Fax: 615-741-0648

<b>State:</b>	Tennessee	<b>Filing Company:</b>	BEST Life and Health Insurance Company
<b>TOI/Sub-TOI:</b>	H10I Individual Health - Dental/H10I.000 Health - Dental		
<b>Product Name:</b>	Stand Alone Dental - Individual Market		
<b>Project Name/Number:</b>	Form Filing/Exchange Products		

## Form Schedule

Lead Form Number: GPD-IM-PPO-POL-0113TN								
Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved 08/12/2013	Individual Market Pediatric Dental Group Policy	IFD-PPO-POL-0113TN	POL	Initial		43.500	IFD-PPO-POL-0113TN(3).pdf
2	Approved 08/12/2013	Individual Market Pediatric Dental Certificate		CER	Initial		43.500	
3	Approved 08/12/2013	Individual Market Pediatric Dental Statement of Variability		MTX	Initial		43.500	
4	Approved 08/12/2013	Individual Market Family or Child Dental Policy	IFD-PPO-POL-0113TN	POL	Initial		43.500	IFD-PPO-POL-0113TN.pdf, IFD-PPO-POL-0113TN_redline.pdf
5	Approved 08/12/2013	Individual Market Family or Child Outline of Coverage	IFD-PPO-OC-0113TN	OUT	Initial			IFD-PPO-OC-0113TN(3).pdf
6	Approved 08/12/2013	Individual Market Family Dental Variability Statement	IFD-PPO-SOV-0113TN	MTX	Initial			IFD-PPO-SOV-0113TN.pdf

### Form Type Legend:

<b>ADV</b>	Advertising	<b>AEF</b>	Application/Enrollment Form
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<b>State:</b>	Tennessee	<b>Filing Company:</b>	BEST Life and Health Insurance Company
<b>TOI/Sub-TOI:</b>	H10I Individual Health - Dental/H10I.000 Health - Dental		
<b>Product Name:</b>	Stand Alone Dental - Individual Market		
<b>Project Name/Number:</b>	Form Filing/Exchange Products		

<b>CER</b>	Certificate	<b>CERA</b>	Certificate Amendment, Insert Page, Endorsement or Rider
<b>DDP</b>	Data/Declaration Pages	<b>FND</b>	Funding Agreement (Annuity, Individual and Group)
<b>MTX</b>	Matrix	<b>NOC</b>	Notice of Coverage
<b>OTH</b>	Other	<b>OUT</b>	Outline of Coverage
<b>PJK</b>	Policy Jacket	<b>POL</b>	Policy/Contract/Fraternal Certificate
<b>POLA</b>	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	<b>SCH</b>	Schedule Pages

**BEST Life and Health Insurance Company**  
[2505 McCabe Way  
Irvine, California 92614]

A STOCK COMPANY  
(Herein called the Company)

**BEST Life and Health Insurance Company ("BEST Life")** is issuing this Policy in consideration of the accuracy of representations made in Your application and Your payment of premiums for Policy coverage.

**READ YOUR POLICY CAREFULLY:** This Policy is a legal contract between You (owner of this Policy) and Us.

**GOVERNING JURISDICTION:** The Policy is issued in the State of Tennessee. It shall be construed in accordance with the laws of the issuing State.

**NOTICE OF TEN DAY RIGHT TO EXAMINE:** We want You to fully understand and be satisfied with the insurance coverage. If for any reason You are not satisfied, You may return this Policy to Your agent or to Our home office within ten (10) days of receipt and Your premium will be fully refunded. Coverage will then be void retroactive to the Insurance Effective Date.

**RENEWAL AND PREMIUM PAYMENT PROVISIONS:** You may renew this Policy for additional coverage periods by paying the premium when due or within the Grace Period until the Insureds reach the maximum eligibility age. Each period of coverage runs from premium due date to premium due date. We reserve the right to change premiums. Any such change will be made according to the table of premium rates that will apply to all policies with the same form and class in Your State. All future renewal premiums will be based on Your original issue age. We will notify You of any premium rate increase at least sixty (60) days in advance. We cannot cancel this Policy while it is in force.

**IN WITNESS WHEREOF,** We have caused this Policy to be signed by Our President and Our Secretary. This Policy takes effect at 12:01 a.m. at Your residence on its Effective Date. This Policy terminates at 12:01 a.m. on the date any renewal premium is due and not paid, subject to the Grace Period.

[



II



**President**

**Secretary**

**Dental PPO Insurance Policy**

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### Unless There Is a Complete Statement of Coverage

## Statement of Coverage

## DENTAL

**POLICY EFFECTIVE DATE:** [01/01/2014]

**INSURED NAME(S) AND EFFECTIVE DATE(S):**

[JANE DOE                      01/01/2014]

[JON DOE                      01/01/2014]

[PLAN: [PPO HIGH]

**DEDUCTIBLE:** **[\$50]**

**ANNUAL MAXIMUM: [\$1,000]**

**PEDIATRIC DENTAL PLAN: [PPO HIGH]**

**DEDUCTIBLE:** [\$50]

**OUT OF POCKET MAXIMUM:** [\$700]

**POLICY NO.:** [XXXXXXXXXX]

## TABLE OF CONTENTS

PART 1 -	SCHEDULE OF BENEFITS.....	[X]
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PART 4 -	DEFINITIONS.....	[X]
PART 5 -	COVERAGE EFFECTIVE AND TERMINATION DATES.....	[X]
PART 6 -	PREMIUM PROVISIONS.....	[X]
PART 7 -	GENERAL PROVISIONS.....	[X]
PART 8 -	FILING A DENTAL CLAIM.....	[X]
ENDORSEMENT – SUPPLEMENTAL FAMILY DENTAL INSURANCE .....		[X]

## PART 1 - SCHEDULE OF BENEFITS

This Policy is made valid on the effective dates shown for the listed Insureds on the Statement of Coverage.

Covered Services received by Insured from a Network Provider are reimbursed at the Network Provider's contracted Fee Schedule. Covered Services received by Insured from an Out-of-Network Provider are reimbursed at the [80th or 90th] percentile of a Usual, Reasonable and Customary schedule. All Covered Services are subject to Cost Sharing as shown on this Schedule of Benefits.

### Pediatric Dental Plan Schedule of Benefits For Children to Age 19

Procedure Categories	[BEST Life Child Dental] [Plus] High Pediatric Dental Plan	
	In-Network [Network Name]	Out-of-Network
<b>Out-of-Pocket Maximum</b>	\$700 for 1 Child \$1,400 for 2 or more Children	\$700 for 1 Child \$1,400 for 2 or more Children
<b>Annual Deductible</b> – Applies to Class I Services received Out-of-Network as well as Class II and III Services received In-Network or Out-of-Network	\$0	\$50
<b>Class I - Basic Services Coinsurance</b> [ – Exams, cleanings, sealants, fluoride treatment, x-rays]	100%	90%
<b>Class II - Intermediate Services Coinsurance</b> [ – Fillings]	70%	60%
<b>Class III - Major Services Coinsurance</b> [ – Crowns & casts, prosthodontics, endodontics, periodontics, oral surgery]	50%	40%
<b>Class IV - Medically Necessary Orthodontic Services Coinsurance</b>	50% [24 Month Wait]	50% [24 Month Wait]

]

[

<b>[BEST Life Child Dental] Low Pediatric Dental Plan</b>		
<b>Procedure Categories</b>	<b>In-Network [Network Name]</b>	<b>Out-of-Network</b>
<b>Out-of-Pocket Maximum</b>	\$700 for 1 Child \$1,400 for 2 or more Children	\$700 for 1 Child \$1,400 for 2 or more Children
<b>Annual Deductible</b> – Applies to Class I, II and III services received In-Network or Out-of-Network	\$50	\$100
<b>Class I - Basic Services Coinsurance</b> [ – Exams, cleanings, sealants, fluoride treatment, x-rays]	100%	60%
<b>Class II - Intermediate Services Coinsurance</b> [ – Fillings]	55%	40%
<b>Class III - Major Services Coinsurance</b> [ – Crowns & casts, prosthodontics, endodontics, periodontics, oral surgery]	35%	20%
<b>Class IV - Medically Necessary Orthodontic Services Coinsurance</b>	50% [24 Month Wait]	50% [24 Month Wait]

]

## PART 2 - BENEFITS AND EXCLUSIONS

### COVERED SERVICES ON PEDIATRIC DENTAL PLAN

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Policy.

#### **Class I – Basic Services:**

- (1) Prophylaxis not more often than once every six (6) months;
- (2) Topical application of fluoride (excluding prophylaxis) not more often than twice every twelve (12) months;
- (3) Topical fluoride varnish not more often than twice every twelve (12) months;
- (4) Sealants not more often than once per tooth in a thirty-six (36) month period and limited to unrestored permanent molars for individuals under age nineteen (19);
- (5) Space maintainers, including re-cementation, for individuals under age nineteen (19) (excluding removal of fixed space maintainer);
- (6) Periodic oral evaluation not more often than once every six (6) months;
- (7) Limited oral evaluation (problem focused) not more often than once every six (6) months;
- (8) Comprehensive oral evaluation not more often than once every six (6) months;
- (9) Comprehensive periodontal evaluation not more often than once every six (6) months;
- (10) Intraoral complete X-rays or panoramic film not more often than once in a 60-month period;
- (11) Bitewing X-rays not more often than one set every six (6) months;
- (12) Single film intraoral periapical or occlusal;

- (13) Palliative treatment of dental pain (minor procedure);

**Class II – Intermediate Service:**

- (1) Amalgams, resin-based composites, re-cement inlays, re-cement crowns, protective restoration, pin retention;
- (2) Prefabricated stainless steel crowns not more often than once per tooth in a sixty (60) month period for individuals under age fifteen (15);
- (3) Therapeutic pulpotomy (excluding restoration) if a root canal is not performed within forty-five (45) days of the pulpotomy;
- (4) Partial pulpotomy for apexogenesis limited to permanent tooth with incomplete root development, if a root canal is not performed within forty-five (45) days of pulpotomy;
- (5) Pulpal therapy (excluding final restoration) once per tooth per lifetime, limited to primary incisor teeth for individuals up to age six (6), and limited to primary molars and cuspids for individuals up to age eleven (11);
- (6) Periodontal scaling and root planning, per quadrant, not more often than once every twenty-four (24) months;
- (7) Periodontal maintenance not more often than four in a twelve (12)-month period, combined with adult prophylaxis after the completion of active periodontal therapy;
- (8) Adjustment and repair of complete or partial dentures;
- (9) Rebase and reline not more often than once in a thirty-six (36) month period, six (6) months after initial installation;
- (10) Tissue conditioning;
- (11) Recement fixed partial denture
- (12) Fixed partial denture repair, by report;
- (13) Oral surgery:
  - a. extraction for erupted tooth or exposed root;
  - b. surgical removal of erupted tooth;
  - c. removal of impacted tooth;
  - d. removal of residual tooth roots;
  - e. coronectomy;
  - f. tooth reimplantation;
  - g. surgical access of unerupted tooth;
  - h. alveoloplasty;
  - i. removal of exostosis;
  - j. incision and drainage of abscess;
  - k. suture of recent small wounds up to five (5) cm
  - l. excision of pericoronal gingival;

**Class III – Major Services:**

- (1) Detailed and extensive oral evaluation;
- (2) Inlays, onlays, crowns, core buildup, including any pins, prefabricated post and core in addition to crown, limited to one per tooth every sixty (60) months;
- (3) Endodontics (root canal)
- (4) Gingivectomy or gingivoplasty, four (4) or more teeth not more often than once every thirty-six (36) months;
- (5) Gingival flap procedure, four (4) or more teeth not more often than once every thirty-six (36) months;
- (6) Osseous surgery, four (4) or more contiguous teeth or bounded teeth spaces per quadrant, not more often than once every thirty-six (36) months;
- (7) Full mouth debridement limited to one (1) per lifetime;
- (8) Complete and partial dentures, including abutments, pontics, onlays, retainers and crowns, not more often than once every sixty (60) months (excludes interim dentures);



- (9) Implants and implant services once every sixty (60) months only if medically necessary;
- (10) Occlusal guard not more often than once in twelve (12) months for individuals thirteen (13) and older with predetermination only;
- (11) General anesthesia or IV sedation;
- (12) Consultation by dentist or physician other than the dentist providing treatment;
- (13) Therapeutic drug injection with predetermination;
- (14) Treatment of post-surgical complications with predetermination.

[**Note:** Unless the twenty-four (24) month waiting period requirement for Medically Necessary Orthodontic services has been met, the services below are not covered benefits for any treatment that began during the twenty-four (24) month period immediately following Your effective date of coverage.]

**Class IV – Medically Necessary Orthodontic Procedures Include:**

- (1) For orthodontia services associated with the repair of cleft palate and palate or other severe craniofacial defects or injury for which the function of speech, swallowing or chewing is restored;
- (2) Requires predetermination; and
- (3) Coverage includes diagnosis, treatment plan, anticipated treatment time and cost estimate.

**EXCLUSIONS ON  
PEDIATRIC DENTAL PLAN**

The following exclusions are not Covered Services. No payments will be made by Us for these services:

- (1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;
- (2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
- (3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
- (4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;
- (5) Services and supplies started and not completed before the patient was covered under this Plan, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
- (6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
- (7) Space maintainers;
- (8) Sealants if re-sealed within a five (5) year period;
- (9) Retreatment of a previous root canal or apicoectomy/periradicular surgery;
- (10) Elective tooth extractions;
- (11) Separate payments for open and drain palliative procedure when the root canal is completed on the same date of service;
- (12) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are defined as a Covered Dental Expense;
- (13) Charges in excess of Usual, Reasonable and Customary charges amount stated in the "Schedule of Benefits" section of this Plan, or in excess of the Preferred Provider Fee Schedule;
- (14) Charges for service provided for temporomandibular joint dysfunction (TMJ);
- (15) Expenses incurred for congenital or developmental malformations, except as defined as a

Covered Orthodontic Expense;

- (16) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits, except as defined as a Covered Orthodontic Expense;
- (17) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
- (18) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, the patient's lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;
- (19) Expenses for services for which the patient would not legally have to pay if there were no insurance, unless mandated by the State;
- (20) Services not completed on or before the date of termination;
- (21) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
- (22) Expenses that are applied toward satisfaction of a Deductible, if any;
- (23) Any service or procedure not commonly found within the scope of practice by a licensed dentist;
- (24) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
- (25) Chemotherapeutic agents and any other experimental procedures;
- (26) Expenses incurred for veneers and related procedures;
- (27) Services and supplies performed outside of the United States of America.

### **PART 3 - LIMITATIONS AND COST SHARING**

#### **ACCESS TO CARE**

##### **Using a Network Provider:**

BEST Life offers Insureds the option to save on out-of-pocket costs when care is provided by a Network Provider. A listing of General Dentists and Specialists is available. To find a Network Provider, please refer to the Network information provided on the ID Card.

##### **How to Select a Dentist:**

Insureds on this Plan may obtain dental services from any licensed dental professional in the United States. To use the Plan, Insureds may directly contact the dentist of their choice and make an appointment. Insureds are advised to bring their ID Card to their appointment. The dentist may require a copy of the Insured's ID Card to confirm eligibility on this Plan.

##### **How to Obtain a Referral:**

A dentist may determine that an Insured requires treatment from a dental provider that specializes in a type of dentistry (Specialist). The Insured does not need to contact BEST Life for a referral. The Insured can directly contact the Specialist to make an appointment. The Specialist may require information from the Insured's dentist to determine a treatment plan and may contact the dentist directly.

#### **ADVANCE NOTICE OF DENTAL TREATMENT**

Policyholder or Insured should submit Advance Notice of Dental Treatment before treatment commences in order to obtain Predetermination of Covered Services, including services that are medically necessary. If dental services are performed without such Predetermination, We reserve the right to deny any claim submitted with respect to such Covered Services; provided however, that

predetermination is not required for:

- (1) Covered Services for which the related expense is less than \$500 during any course of treatment ("course of treatment" means one treatment or one of a planned series of treatments resulting from dental examination);
- (2) Emergency treatment; or
- (3) Oral examination and prophylaxis.

Predetermination is required for the following dental services for children:

- (1) Medically necessary services or supplies;
- (2) Panoramic film for children under age six (6);
- (3) Periodontal scaling and root planing;
- (4) Occlusal orthotic devices;
- (5) Appliance therapy;
- (6) Orthodontia, including preorthodontic treatment visit.

Predetermination is required for the following dental services for adults and children 19 or older:

- (1) Crowns, Anterior, except with posts or root canal;
- (2) Crowns, 2 or more Posterior, except with posts or root canal;
- (3) Inlays or Onlays, 2 or more, except with posts or root canal;
- (4) Laminates;
- (5) Anterior composites;
- (6) 2 or more multiple surfaces;
- (7) Bridges – initial or replacement;
- (8) Eligible partial dentures – initial or replacement;
- (9) Periodontal surgery over \$500;
- (10) Full bony impactions, 2 or more.

We will have thirty (30) days to furnish the provider with an Explanation of Benefits demonstrating whether the proposed treatment will be a Covered Service under this Policy.

## **DEDUCTIBLES**

**Annual Deductible:** The Annual Deductible shown in the Schedule of Dental Benefits will apply separately to each Insured. Each Insured must accumulate eligible expenses equal to the deductible amount.

## **ALTERNATIVE PROCEDURES**

If more than one treatment plan exists for a dental procedure, covered dental expenses will be based on the least expensive procedure that will produce a result that meets professionally recognized standards. If the Insured's provider elects the more expensive treatment, the Insured or Policyholder shall be responsible for any charges that are greater than the covered expense for the less expensive treatment.

## **PART 4 - DEFINITIONS**

**Annual:** The twelve (12) month period beginning on the effective date of the Certificate and ending on the termination date of the Certificate. The Annual time frame will be applied to the Deductible and

the Annual Maximum amount.

**Annual Deductible:** The amount each Insured must satisfy before Benefits are payable by Us. To satisfy the Annual Deductible, the Insured must accumulate expenses for Covered Services equal to the Deductible amount shown on the Schedule of Benefits.

**Annual Maximum:** The maximum amount BEST Life will reimburse for covered services during a twelve (12) month period for each Insured person. Once the full Annual Maximum amount has been paid, no additional services will be reimbursed for the remainder of that year. The

**Child:** A dependent child who meets the definition of Eligible Person may be enrolled and covered under this Policy, as follows:

1. A child who is less than nineteen (19) years of age on the coverage effective date will be covered on the Pediatric Dental Plan until that child is nineteen (19) years of age on the renewal date;
2. A child who is older than nineteen (19) years of age on the coverage effective date or renewal date may be covered under the Supplemental Family Dental Insurance, if Supplemental Family Dental Insurance is endorsed onto the policy.

**Coinsurance:** The amount of an expense for a Covered Service that we will pay once the deductible is satisfied.

**Covered Dependent:** A Child who is an Eligible Person and who is enrolled in and covered under an active policy of insurance issued to the Policyholder named on the Statement of Coverage.

**Covered Service:** A service or supply listed as a Covered Service and not otherwise limited or excluded by this Certificate. A Covered Service must be provided by a doctor of medical dentistry or a doctor of dental surgery, or a dentist.

**Eligible Person:**

- (1) You [to age 65]
- (2) Your lawful spouse or domestic partner [to age 65]; and
- (3) Your or Your spouse's or domestic partner's child or children, including a natural child, step-child, foster child, lawfully adopted child or child in the process of being adopted, from the date of placement, or any child for whom You have been granted legal custody, provided they are less than twenty-six (26) years of age; or
- (4) A child named in a Qualified Medical Child Support Order will be considered an Eligible Person.

"Eligible Person" also means a dependent child, who upon reaching the termination age, is unable to sustain employment because of a permanent mental or physical handicap and You notify Us in writing within thirty-one (31) days after the termination age, the child will continue to qualify as a dependent under this plan, provided You and the dependent child continue to be insured under this plan, and the child continues to be handicapped and dependent upon You for support. This shall not apply to a dependent child who is beyond the termination age on the date You become eligible for dependent insurance under this Policy.

**Family Deductible:** The Family Deductible is satisfied when each of three (3) covered members of Your family satisfy the Annual Deductible. Once the combined costs of services provided by covered members of Your family is equal to the Family Deductible amount, no additional Deductible will be required for other insured family members for the remainder of the Calendar Year.

**Emergency Care:** A dental emergency where an acute disorder of oral health requires dental and/or

medical attention, including broken, loose, or evulsed teeth caused by traumas; infections and inflammations of the soft tissues of the mouth; and complications of oral surgery, such as dry tooth socket.

**Insured:** The Policyholder or any Eligible Dependent of a Policyholder who is enrolled in and covered under the Policy.

**Medically Necessary:** The determination process that may include, and not limited to, the evaluation of the effectiveness and benefit of a dental service or supply for the individual patient based on scientific evidence considerations, up-to-date and consistent professional standards of care, convincing expert opinion and a comparison to alternative interventions, including interventions, and the cost effectiveness of such service or supply. Medical necessity may be obtained by applying an Advance Notice of Treatment.

**Network Provider:** A dental care professional that is contracted with Us and is part of the Network shown on the Schedule of Benefits.

**Out-of-Pocket Maximum:** The total amount of expenses related to Covered Services, in addition to the Deductible, that must be paid on behalf of an Insured on an Annual basis.

**Out-of-Network Provider:** A dental care professional that is not a Network Provider.

**Policy Effective Date:** The date shown on the Statement of Coverage as the Policy Effective Date.

**Statement of Coverage:** The proof of insurance issued to an individual insured under the Policy, outlining the insurance benefits and principle provisions applicable to the member.

**Usual, Reasonable and Customary:** The charge for health care that is consistent with the average rate or charge for identical or similar services in a certain geographical area.

**You or Your:** Means the Policyholder.

## **PART 5 – ENROLLMENT, EFFECTIVE DATE AND TERMINATION DATE**

### ***ENROLLMENT***

A person eligible as a Policyholder must:

- (1) Enroll all Eligible Persons in accordance with the annual open enrollment period;
- (2) Enroll all Eligible Persons within thirty (30) days of one of the following triggering events:
  - (a) The date on which an Eligible Person loses minimum essential coverage;
  - (b) A Policyholder gains an new Eligible Person;
  - (c) A person becomes an Eligible Person through marriage, birth, adoption or placement for adoption;
  - (d) An Eligible Person's enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or HHS, or its instrumentalities as evaluated and determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;
  - (e) You adequately demonstrates to the Exchange that the qualified health plan in which You is enrolled substantially violated a material provision of its contract in relation to the You or a Covered Dependent;
  - (f) An Eligible Person gains access to new qualified health plans as a result of a

- permanent move;
- (g) An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a QHP or change from one QHP to another one time per month; and
- (h) An Eligible Person demonstrates other exceptional circumstances.

#### ***EFFECTIVE DATE***

Your insurance will become in effect as follows:

- (1) If enrollment is received between the first (1<sup>st</sup>) and the fifteenth (15<sup>th</sup>) day of the enrollment period, coverage will be effective on the first day of the following month; and
- (2) If enrollment is received between the sixteenth (16<sup>th</sup>) and the last day of the enrollment period, coverage will be effective on the first day of the second following month.

#### ***TERMINATION DATE***

Coverage may be terminated, as follows:

- (1) You may terminate coverage with appropriate notice.
- (2) We may terminate coverage in the following circumstances:
  - (a) You are no longer eligible for coverage through the Exchange;
  - (b) Non-payment of premiums;
  - (c) Your coverage is rescinded;
  - (d) We terminate or decertify; or
  - (e) You change insurance carriers during an annual open enrollment period or special enrollment period.

### **PART 6 –PREMIUM PROVISIONS**

**Premium Payments:** Renewal premiums are payable to the Company. The payment of any premium shall not continue this Policy in force beyond the next premium due date, except as provided in the Grace Period provision.

**Changes in Premiums:** We may change the amount of the required premium due from the Policyholder by giving the Policyholder at least sixty (60) days advance written notice. During the first 12 months, We will not change the amount of the required premium.

**Grace Period:** This Policy has a thirty-one (31) day Grace Period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following thirty-one (31) days. During the Grace Period, this Policy will remain in force. If the required premium is not paid by the end of this Grace Period, this Policy will lapse as of the last day of a month for which you are paid in full.

**Reinstatement:** If any renewal premium is not paid by the end of the Grace Period, coverage under this Policy will be terminated. However, BEST Life will reinstate this Policy, without requiring an application for reinstatement, as long as premium is paid for at least the sixty (60) days prior to the date of reinstatement. The reinstated Policy will cover only loss resulting from an accidental injury sustained after the date of reinstatement and loss due to sickness beginning ten (10) days after reinstatement. In all other respects the insured and BEST Life shall have the same rights as they had under the Policy immediately before the due date of the defaulted premium, subject to conditions and provisions of the Policy.

### **PART 7 – GENERAL PROVISIONS**

**Clerical Error:** Clerical error by the Policyholder shall not invalidate insurance otherwise validly in force nor continue insurance otherwise validly terminated.

**Third Party Responsibility:** If an Insured is injured or becomes ill through the act or omission of another person, to the extent that the Insured recovers medical expenses for the same Injury or Illness from a third party or its insurer, We will be entitled to a repayment of any remuneration in excess of benefits paid under the Policy due to the same Injury or Illness, and after the Insured is fully compensated for his or her loss. We may file a lien for such repayment. Upon request, the Insured must complete and return the required forms to Us.

The repayment agreement will be binding upon the Insured, or the legal representative of a minor or incompetent, whether:

- (1) the payment received from the third party, or its insurer, is the result of:
  - legal judgment;
  - an arbitration award;
  - a compromise settlement;
  - any other arrangements; or
- (2) the third party or its insurer had admitted liability for the payment; or
- (3) the medical expenses are itemized in the third party payment.

**Entire Contract; Changes:** The Policy, including the endorsements, certificates, riders, application and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions. We will consider any statement made by the Insured or the Policyholder, in the absence of fraud, as a representation and not a warranty.

**Underwriting Decisions:** If, for any reason, We cannot accept Your application for coverage, We will communicate Our decision to You in writing with the reasons supporting Our decision.

**Notification to Insureds:** BEST Life will notify Policyholder in writing by mail to Policyholder's last known address at least thirty (30) days prior to the effective date of the termination of your insurance, a change in your premium, a change in eligibility or a change in your benefits.

**Right to Contest:** After this Policy has been in force for a period of two (2) years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application. No claim for loss incurred or disability (as defined in the Policy) commencing after two (2) years from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Policy.

**Notice of Claim:** We must receive written notice within twenty (20) days after a claim starts or as soon as reasonably possible. The notice shall be sent to [BEST Life and Health Insurance Company at 2505 McCabe Way, Irvine, California 92614] or given it to Our agent.

**Claim Forms:** When We receive a notice of claim, We will send forms for filing the claim. If the Policyholder or Insured do not receive these forms within fifteen (15) days, the Policyholder or Insured may send Us a written statement to satisfy this requirement. This statement should include the nature and extent of the claim and be sent to Us within the time stated in the Proof of Loss provision.

**Proof of Loss:** We must receive written proof of loss within ninety (90) days of a claim. If it is not possible for proof to be provided within the ninety (90) days, We will not deny a claim for this reason if We receive

the proof as soon as possible. In any event, We must receive proof no later than one year from the time specified, unless Policyholder is legally incapacitated.

**Time of Payment of Claims:** Indemnities payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this Policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

**Payment of Claims:** All payments will be made to Policyholder or Insured's provider.

**Legal Actions:** A legal action may not be brought against Us before sixty (60) days, or after three (3) years, from the date written proof of loss is required to be given.

**Time Limit on Certain Defenses:** After this Policy has been in force for two (2) years, We will not use any statements made in the application of the Policyholder to void the Policy. After an Insured Person has been covered under this Policy for two (2) years, We will not use any statement made in the Insured Person's enrollment form to defend a claim.

**Misstatement of Age:** If the age of any individual covered under the Policy has been misstated, there shall be an adjustment of premium for the Policy so that there shall be paid to Us the premium for the coverage of such individual at his or her correct age, and the amount of the insurance coverage shall not be affected.

**Worker's Compensation:** The Policy is not in lieu of and does not affect any requirement for coverage by Worker's Compensation Insurance.

**Conformity with State Statutes:** Any provisions of the Policy which are in conflict with the statutes of the state in which the Policy was issued or delivered will be changed to conform to such laws.

**Waiver of Rights:** If We fail to enforce any provision of the Policy, such failure will not affect Our right to do so at a later date, nor will it affect Our right to enforce any other provision of the Policy.

**Inspection of Policy:** The Policy is in the possession of the Policyholder. It may be inspected at any time during business hours at the office of the Policyholder.

**Duty to Cooperate:** As a condition precedent to the payment of benefits hereunder, the Policyholder and Insured are required to cooperate with Us by providing all information reasonably required to accurately process a claim. Any failure to provide necessary information may result in a denial of benefits for the claim.

## **PART 8 – FILING A DENTAL CLAIM**

**HOW TO FILE A CLAIM:** Claim forms may be obtained from [the BEST Life website located at [www.bestlife.com](http://www.bestlife.com), click on "Forms"].

Submit claims to [BEST Life and Health Insurance Company, P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].



For questions about a claim payment, contact [BEST Life's Customer Service at [1-800-433-0088 or at [cs@bestlife.com](mailto:cs@bestlife.com), Monday through Friday, 7 am to 5 pm Pacific Time].

**CLAIMS DENIAL PROCEDURE:** Any denial of a claim for Benefits will be explained in writing. The explanation will include (a) the specific reason for the denial, (b) reference to the plan provision upon which the denial was based, (c) a description of any additional information that might be required to provide and an explanation of why it is needed, and (d) an explanation of the plan's claim review procedure.

**APPEALING THE DENIAL OF A CLAIM:** You or an authorized representative You appoint to assist or represent You, may appeal any denial of a claim, in whole or in part, for Benefits by filing a written request for a review. The request must include all reasons You believe the initial decision was incorrect and all documentation supporting Your appeal, to [BEST Life and Health Insurance Company, Attn: Appeals, P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

A request for a review must be filed within one-hundred and eighty (180) days after the date on which we issue the written notice of denial of a claim. BEST Life and Health Insurance Company will provide an appeal determination not later than sixty (60) days after receipt of a request for review. If there are special circumstances, the decision will be made as soon as possible, but no later than fifteen (15) days after receipt of the request for review. The appeal determination will be in writing and will include specific reasons for the decision. This decision shall also include specific references to the Policy provisions on which the decision was based.

## [ENDORSEMENT - SUPPLEMENTAL FAMILY DENTAL INSURANCE]

If the Policyholder selected Family Dental Coverage, then this Endorsement modifies, supplements, and becomes a part of the Policy. It provides coverage to the enrolled Eligible Persons who are at least 19 years of age until they reach the maximum eligibility age. Except as expressly provided in this Endorsement, all terms and conditions of the Certificate remain unchanged and in full force and effect.

### **Dental Plan Schedule of Benefits** **For Eligible Persons who are at least 19 years of age** **until they reach maximum eligibility age**

	[BESTOne Dental] [Advantage][Plus][Basic] Supplemental Plan	
Benefits Description	In-Network [Network]	Out-of-Network
Annual Maximum	\$[1,000 – 1,500]	
Annual Deductible	\$50	
Basic Services Coinsurance	100%	100%
Intermediate Services Coinsurance	[90-50]%	[90-50]%
Major Services Coinsurance	[60-0]%	[60-0]%

### **COVERED SERVICES ON SUPPLEMENTAL DENTAL PLAN**

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Policy.

#### **CLASS A – Basic Services:**

- (1) Routine oral examination and diagnosis not more often than twice every twelve (12) months per individual;
- (2) Bitewing x-rays not more often than once every twelve (12) months per individual;
- (3) Full mouth x-rays or panoramic films are limited to once every five (5) years; any combination of eight (8) or more x-rays (including but not limited to bitewings or periapicals/intraorals) will be combined into a full mouth x-ray series;
- (4) Prophylaxis not more often than once every six (6) months per individual.

#### **CLASS B – Intermediate Services:**

- (1) Pathology;
- (2) All fillings other than lab fabricated restorations (composite fillings limited to permanent anterior and posterior teeth);
- (3) Emergency palliative treatment;
- (4) Limited oral exam not more than once every six months;
- (5) Simple extraction, excluding orthodontic extractions unless a orthodontic benefits are a Covered Dental Expense on this Plan;

- (6) Surgical extraction, including impaction:
  - (a) erupted tooth;
  - (b) soft tissue impaction;
  - (c) partial bony impaction;
  - (d) complete bony impaction;
- (7) General anesthesia or intravenous sedation when required for complex oral surgical procedures (partial and complete bony impacted extractions only);
- (8) Periodontics (tissues and gums);
- (9) Periodontal exam (not in addition to a routine oral exam);
- (10) Periodontal maintenance (limited to once every six (6) months per individual following active periodontal treatment) and not on the same visit as a routine prophylaxis;
- (11) Periodontal scaling and root planing (limited to once every 36 months and to two (2) quadrants per visit, and not in addition to a routine prophylaxis);
- (12) Endodontics (pulp capping and root canal); and
- (13) Oral surgery:
  - (a) root recovery (surgical removal of residual root);
  - (b) oral antral fistula closure;
  - (c) removal of a dentigerous or odontogenic cyst;
  - (d) incision and drainage of an abscess;
  - (e) removal of lateral exostosis;
  - (f) frenulectomy.

**CLASS C - Major Services:**

- (1) Inlays, onlays, crowns and other lab fabricated restorations (not including veneers);
- (2) Porcelain, porcelain fused to metal, or full gold crowns on permanent teeth;
- (3) Full or partial dentures or fixed bridgework or adding teeth to an existing denture, if required because of loss of functional natural teeth while the person is covered for this Benefit. The work must be done within twelve (12) months after the extraction and while this coverage is in force;
- (4) Replacement or alteration of full or partial dentures or fixed bridgework caused by the following while coverage is in force:
  - (a) accidental injury requiring oral surgical treatment, or
  - (b) oral surgical treatment involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus or redundant tissue, provided the replacement or alteration is done within twelve (12) months of the injury or surgical treatment.
- (5) Replacement of a full denture or bridgework if the replacement is made more than seven (7) years after the date of installation, unless:
  - (a) such replacement is made necessary by the initial extraction of an adjoining functional natural tooth; or
  - (b) the prosthesis, while in the oral cavity, has been damaged beyond repair as a result of a non-chewing injury while covered;
- (6) Repair or relining of dentures and bridgework[;]
- (7) Implants, as an alternative to a fixed prosthetic, (limited to once in a lifetime per site). The cost of the fixed prosthetic will be applied to the total value of the implant and implant-related procedures, not to exceed the cost of the fixed prosthetic:
  - (a) the surgical placement of endosteal implant body including healing cap, where the bone and soft tissues are sound and healthy;
  - (b) implant supported prosthetics;
  - (c) eposteal and transosteal implants will be covered at the cost of the endosteal implant (if performed, member is responsible for additional fees);
  - (d) bone grafting and tooth extractions, provided the work is done while this coverage is in force;
  - (e) implant maintenance[.].

## EXCLUSIONS ON SUPPLEMENTAL DENTAL PLAN

The following exclusions are not Covered Services. No payments will be made by Us for these services:

- (1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;
- (2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
- (3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
- (4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;
- (5) Services and supplies begun and not completed prior to the patient's effective date, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
- (6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
- (7) Pulp capping, if in conjunction with the installation of inlays, onlays or crowns and fillings or other lab fabricated restorations; including but not limited to inlays, onlays and crowns, preventative tests and examinations diagnostic casts and oral cancer screenings, and expenses incurred for sedative fillings, including charges for prescribed drugs, pre-medication or analgesia;
- (8) The initial installation of a prosthetic device (a fixed bridge, implant, or denture), including crowns and inlays which form abutments, to replace teeth missing before You were covered under the Policy, except when it also replaces a tooth that is extracted while covered unless such installation commences after You have remained continuously covered under this plan for at least three years immediately prior to the date such installation commences;
- (9) Implants, implant services and implant supported prosthetics;
- (10) Expenses incurred for veneers and related procedures;
- (11) Replacement of a lost or stolen or discarded prosthetic device;
- (12) Adjustment, repairs or relines of prostheses for a period of one (1) year from initial placement if the prostheses were paid for under this plan;
- (13) Expenses incurred for a core buildup will only be considered in conjunction with a crown;
- (14) If multiple endodontic treatments are necessary on the same tooth within a period of one (1) year, the allowance will be made for only one (1) procedure;
- (15) X-rays are considered an integral part of the endodontic procedure rather than a separate service and are therefore not eligible for benefits;
- (16) The extraction of immature erupting third molars and non-pathologic, asymptomatic third molar extractions;
- (17) Expenses for gross debridement allowed one time at the beginning of the periodontal treatment plan prior to pocket depth charting;
- (18) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
- (19) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are a Covered Dental Expense on this Plan;

- (20) Surgical procedures incidental to orthodontic treatment, including but not limited to, extraction of teeth solely for orthodontic reasons, exposure of impacted teeth, correction of micrognathia or macrognathia, or repair of cleft palate;
- (21) Charges for service provided for temporomandibular joint dysfunction (TMJ);
- (22) Expenses incurred for congenital or developmental malformations;
- (23) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
- (24) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits;
- (25) Chemotherapeutic agents and any other experimental procedures;
- (26) Charges in excess of the In-Network Provider Fee Schedule for the services in the area where treatment was received or charges in excess of the Calendar Year Maximum amount stated in the "Schedule of Dental Benefits" section of this Plan;
- (27) Expenses that are applied toward satisfaction of a Deductible, if any;
- (28) Services and supplies performed outside of the United States of America;
- (29) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, Your lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;
- (30) Expenses for services for which You would not legally have to pay if there were no insurance;
- (31) Services not completed on or before the date of termination;
- (32) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
- (33) Any service or procedure not commonly found within the scope of practice by a licensed dentist. Such procedures are identified within the current Common Dental Terminology (CDT Codes) published by the American Dental Association;
- (34) Expenses incurred for services covered on a pediatric only dental plan.]

**Underwritten by BEST Life and Health Insurance Company**



# Individual Insurance Policy

## Dental PPO Plan



[2505 McCabe Way  
Irvine, California 92614]

**Notice to Buyer: This Policy provides dental coverage only.**

**BEST Life and Health Insurance Company**  
[2505 McCabe Way  
Irvine, California 92614]

A STOCK COMPANY  
(Herein called the Company)

**BEST Life and Health Insurance Company ("BEST Life")** is issuing this Policy in consideration of the accuracy of representations made in Your application and Your payment of premiums for Policy coverage.

**READ YOUR POLICY CAREFULLY:** This Policy is a legal contract between You (owner of this Policy) and Us.

**GOVERNING JURISDICTION:** The Policy is issued in the State of Tennessee. It shall be construed in accordance with the laws of the issuing State.

**NOTICE OF TEN DAY RIGHT TO EXAMINE:** We want You to fully understand and be satisfied with the insurance coverage. If for any reason You are not satisfied, You may return this Policy to Your agent or to Our home office within ten (10) days of receipt and Your premium will be fully refunded. Coverage will then be void retroactive to the Insurance Effective Date.

**RENEWAL AND PREMIUM PAYMENT PROVISIONS:** You may renew this Policy for additional coverage periods by paying the premium when due or within the Grace Period until the Insureds reach age [19][65]. Each period of coverage runs from premium due date to premium due date. We reserve the right to change premiums. Any such change will be made according to the table of premium rates that will apply to all policies with the same form and class in Your State. All future renewal premiums will be based on Your original issue age. We will notify You of any premium rate increase at least sixty (60) days in advance. We cannot cancel this Policy while it is in force.

**IN WITNESS WHEREOF,** We have caused this Policy to be signed by Our President and Our Secretary. This Policy takes effect at 12:01 a.m. at Your residence on its Effective Date. This Policy terminates at 12:01 a.m. on the date any renewal premium is due and not paid, subject to the Grace Period.

[



**President**

II



**Secretary**

**Dental PPO Insurance Policy**



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### Unless There Is a Complete Statement of Coverage

## Statement of Coverage

## DENTAL

**POLICY EFFECTIVE DATE:** [01/01/2014]

**INSURED NAME(S) AND EFFECTIVE DATE(S):**

[JANE DOE                      01/01/2014]

[JON DOE                      01/01/2014]

[PLAN: [PPO HIGH]

**DEDUCTIBLE:** [\$50]

**ANNUAL MAXIMUM: [\$1,000]**

**PEDIATRIC DENTAL PLAN: [PPO HIGH]**

**DEDUCTIBLE:** [\$50]

**OUT OF POCKET MAXIMUM: [\$700]]**

**POLICY NO.:** [XXXXXXXXXX]

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## PART 1 - SCHEDULE OF BENEFITS

This Policy is made valid on the effective dates shown for the listed Insureds on the Statement of Coverage.

Covered Services received by Insured from a Network Provider are reimbursed at the Network Provider's contracted Fee Schedule. Covered Services received by Insured from an Out-of-Network Provider are reimbursed at the [80th or 90th] percentile of a Usual, Reasonable and Customary schedule. All Covered Services are subject to Cost Sharing as shown on this Schedule of Benefits.

### [Pediatric Dental Plan Schedule of Benefits For Children to Age 19]

	<b>[BEST Life Child Dental] [Plus] Pediatric Dental Plan</b>	
<b>Procedure Categories</b>	<b>In-Network [Network Name]</b>	<b>Out-of-Network</b>
<b>Out-of-Pocket Maximum</b>	\$700 for 1 Child \$1,400 for 2 or more Children	\$700 for 1 Child \$1,400 for 2 or more Children
<b>Annual Deductible</b> – Applies to Preventive[,] [services received Out-of-Network as well as] Basic and Major services received In-Network or Out-of-Network	\$[0][50]	\$[50][100]
<b>Diagnostic &amp; Preventive Services Coinsurance</b> – Exams, cleanings, sealants, fluoride treatment, x-rays	100%	[90][60]%
<b>Basic Services Coinsurance</b> – Fillings	[70][55]%	[60][40]%
<b>Major Services Coinsurance</b> – Crowns & casts, prosthodontics, endodontics, periodontics, oral surgery	[50][35]%	[40][20]%
<b>Orthodontic Services Coinsurance</b> (Medically necessary Orthodontic Services only)	50% [24 Month Wait]	50% [24 Month Wait]

**[Dental Plan Schedule of Benefits  
For Adults and Dependent Children between 19 and 26]**

	<b>[BESTOne Dental] [Advantage][Plus][Basic] Supplemental Plan</b>	
<b>Benefits Description</b>	<b>In-Network [Network]</b>	<b>Out-of-Network</b>
<b>Annual Maximum</b>	\$[500 – 3,500]	
<b>Annual Deductible</b> (Applies to Basic and Major) – 3 Deductible Maximum per Family	[\$0-100]	
<b>Preventive Care Services</b> Routine oral exam, cleanings, X-rays	[100-70]%	[100-70]%
<b>Basic Services</b> Fillings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology	[90-50]%	[80-20]%
<b>Major Services</b> Crowns & gold fillings, inlays, onlays & pontics, [implants,] fixed bridges, complete & partial dentures	[60-0]%	[50-0]%
<b>[Major Services Waiting Period]</b>	12 Months]	
<b>Endodontic Services</b>	[Basic][Major]	
<b>Periodontic Services</b>	[Basic][Major]	
<b>Oral Surgery Services</b>	[Basic][Major]	
<b>Usual and Customary Reimbursement</b>	Fee Schedule	[80 <sup>th</sup> ][90 <sup>th</sup> ] Percentile

**PART 2 - BENEFITS AND EXCLUSIONS**

**COVERED SERVICES ON  
PEDIATRIC DENTAL PLAN**

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Policy.

**Class I – Preventive and Diagnostic Procedures Include:**

- (1) Prophylaxis not more often than once every six (6) months;
- (2) Topical application of fluoride (excluding prophylaxis) not more often than twice every twelve (12) months;
- (3) Topical fluoride varnish not more often than twice every twelve (12) months;
- (4) Sealants not more often than once per tooth in a thirty-six (36) month period and limited to unrestored permanent molars for individuals under age nineteen (19);
- (5) Space maintainers, including re-cementation, for individuals under age nineteen (19) (excluding removal of fixed space maintainer);
- (6) Periodic oral evaluation not more often than once every six (6) months;
- (7) Limited oral evaluation (problem focused) not more often than once every six (6) months;
- (8) Comprehensive oral evaluation not more often than once every six (6) months;
- (9) Comprehensive periodontal evaluation not more often than once every six (6) months;
- (10) Intraoral complete X-rays or panoramic film not more often than once in a 60-month period;
- (11) Bitewing X-rays not more often than one set every six (6) months;
- (12) Single film intraoral periapical or occlusal;

- (13) Palliative treatment of dental pain (minor procedure);

**Class II – Basic Procedures Include:**

- (1) Amalgams, resin-based composites, re-cement inlays, re-cement crowns, protective restoration, pin retention;
- (2) Prefabricated stainless steel crowns not more often than once per tooth in a sixty (60) month period for individuals under age fifteen (15);
- (3) Therapeutic pulpotomy (excluding restoration) if a root canal is not performed within forty-five (45) days of the pulpotomy;
- (4) Partial pulpotomy for apexogenesis limited to permanent tooth with incomplete root development, if a root canal is not performed within forty-five (45) days of pulpotomy;
- (5) Pulpal therapy (excluding final restoration) once per tooth per lifetime, limited to primary incisor teeth for individuals up to age six (6), and limited to primary molars and cuspids for individuals up to age eleven (11);
- (6) Periodontal scaling and root planning, per quadrant, not more often than once every twenty-four (24) months;
- (7) Periodontal maintenance not more often than four in a twelve (12)-month period, combined with adult prophylaxis after the completion of active periodontal therapy;
- (8) Adjustment and repair of complete or partial dentures;
- (9) Rebase and reline not more often than once in a thirty-six (36) month period, six (6) months after initial installation;
- (10) Tissue conditioning;
- (11) Recement fixed partial denture
- (12) Fixed partial denture repair, by report;
- (13) Oral surgery:
  - a. extraction for erupted tooth or exposed root;
  - b. surgical removal of erupted tooth;
  - c. removal of impacted tooth;
  - d. removal of residual tooth roots;
  - e. coronectomy;
  - f. tooth reimplantation;
  - g. surgical access of unerupted tooth;
  - h. alveoloplasty;
  - i. removal of exostosis;
  - j. incision and drainage of abscess;
  - k. suture of recent small wounds up to five (5) cm
  - l. excision of pericoronal gingival;

**Class III – Major Procedures Include:**

- (1) Detailed and extensive oral evaluation;
- (2) Inlays, onlays, crowns, core buildup, including any pins, prefabricated post and core in addition to crown, limited to one per tooth every sixty (60) months;
- (3) Endodontics (root canal)
- (4) Gingivectomy or gingivoplasty, four (4) or more teeth not more often than once every thirty-six (36) months;
- (5) Gingival flap procedure, four (4) or more teeth not more often than once every thirty-six (36) months;
- (6) Osseous surgery, four (4) or more contiguous teeth or bounded teeth spaces per quadrant, not more often than once every thirty-six (36) months;
- (7) Full mouth debridement limited to one (1) per lifetime;

- (8) Complete and partial dentures, including abutments, pontics, onlays, retainers and crowns, not more often than once every sixty (60) months (excludes interim dentures);
- (9) Implants and implant services once every sixty (60) months only if medically necessary;
- (10) Occlusal guard not more often than once in twelve (12) months for individuals thirteen (13) and older with predetermination only;
- (11) General anesthesia or IV sedation;
- (12) Consultation by dentist or physician other than the dentist providing treatment;
- (13) Therapeutic drug injection with predetermination;
- (14) Treatment of post-surgical complications with predetermination.

[**Note:** Unless the twenty-four (24) month waiting period requirement for Medically Necessary Orthodontic services has been met, the services below are not covered benefits for any treatment that began during the twenty-four (24) month period immediately following Your effective date of coverage.]

**Class IV – Medically Necessary Orthodontic Procedures Include:**

- (1) For orthodontia services associated with the repair of cleft palate and palate or other severe craniofacial defects or injury for which the function of speech, swallowing or chewing is restored;
- (2) Requires predetermination; and
- (3) Coverage includes diagnosis, treatment plan, anticipated treatment time and cost estimate.

**EXCLUSIONS ON  
PEDIATRIC DENTAL PLAN**

The following exclusions are not Covered Services. No payments will be made by Us for these services:

- (1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;
- (2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
- (3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
- (4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;
- (5) Services and supplies started and not completed before the patient was covered under this Plan, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
- (6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
- (7) Space maintainers;
- (8) Sealants if re-sealed within a five (5) year period;
- (9) Retreatment of a previous root canal or apicoectomy/periradicular surgery;
- (10) Elective tooth extractions;
- (11) Separate payments for open and drain palliative procedure when the root canal is completed on the same date of service;
- (12) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are defined as a Covered Dental Expense;
- (13) Charges in excess of Usual, Reasonable and Customary charges amount stated in the "Schedule

- of Benefits" section of this Plan, or in excess of the Preferred Provider Fee Schedule;
- (14) Charges for service provided for temporomandibular joint dysfunction (TMJ);
  - (15) Expenses incurred for congenital or developmental malformations, except as defined as a Covered Orthodontic Expense;
  - (16) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits, except as defined as a Covered Orthodontic Expense;
  - (17) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
  - (18) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, the patient's lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;
  - (19) Expenses for services for which the patient would not legally have to pay if there were no insurance, unless mandated by the State;
  - (20) Services not completed on or before the date of termination;
  - (21) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
  - (22) Expenses that are applied toward satisfaction of a Deductible, if any;
  - (23) Any service or procedure not commonly found within the scope of practice by a licensed dentist;
  - (24) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
  - (25) Chemotherapeutic agents and any other experimental procedures;
  - (26) Expenses incurred for veneers and related procedures;
  - (27) Services and supplies performed outside of the United States of America.

#### **[COVERED SERVICES ON SUPPLEMENTAL DENTAL PLAN**

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Policy.

##### **CLASS I - Preventive Dental Procedures include:**

- (1) Routine oral examination and diagnosis not more often than twice every twelve (12) months per individual;
- (2) Bitewing x-rays not more often than once every twelve (12) months per individual;
- (3) Full mouth x-rays or panoramic films are limited to once every five (5) years; any combination of eight (8) or more x-rays (including but not limited to bitewings or periapicals/intraorals) will be combined into a full mouth x-ray series;
- (4) Prophylaxis not more often than once every six (6) months per individual.

##### **CLASS II - Basic Dental Procedures include:**

- (1) Pathology;
- (2) All fillings other than lab fabricated restorations (composite fillings limited to permanent anterior and posterior teeth);
- (3) Emergency palliative treatment;
- (4) Limited oral exam not more than once every six months;
- (5) Simple extraction, excluding orthodontic extractions unless a orthodontic benefits are a Covered Dental Expense on this Plan;



- (6) Surgical extraction, including impaction:
  - (a) erupted tooth;
  - (b) soft tissue impaction;
  - (c) partial bony impaction;
  - (d) complete bony impaction;
- (7) General anesthesia or intravenous sedation when required for complex oral surgical procedures (partial and complete bony impacted extractions only);
- (8) Periodontics (tissues and gums);
- (9) Periodontal exam (not in addition to a routine oral exam);
- (10) Periodontal maintenance (limited to once every six (6) months per individual following active periodontal treatment) and not on the same visit as a routine prophylaxis;
- (11) Periodontal scaling and root planing (limited to once every 36 months and to two (2) quadrants per visit, and not in addition to a routine prophylaxis);
- (12) Endodontics (pulp capping and root canal); and
- (13) Oral surgery:
  - (a) root recovery (surgical removal of residual root);
  - (b) oral antral fistula closure;
  - (c) removal of a dentigerous or odontogenic cyst;
  - (d) incision and drainage of an abscess;
  - (e) removal of lateral exostosis;
  - (f) frenulectomy.

[**Note:** Unless the twelve (12) month waiting period requirement for Major Dentistry services has been met, the services below are not covered benefits for any treatment that began during the twelve (12) month period immediately following Your effective date of coverage.]

**CLASS III - Major Dental Procedures include:**

- (1) Inlays, onlays, crowns and other lab fabricated restorations (not including veneers);
- (2) Porcelain, porcelain fused to metal, or full gold crowns on permanent teeth;
- (3) Full or partial dentures or fixed bridgework or adding teeth to an existing denture, if required because of loss of functional natural teeth while the person is covered for this Benefit. The work must be done within twelve (12) months after the extraction and while this coverage is in force;
- (4) Replacement or alteration of full or partial dentures or fixed bridgework caused by the following while coverage is in force:
  - (a) accidental injury requiring oral surgical treatment, or
  - (b) oral surgical treatment involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus or redundant tissue, provided the replacement or alteration is done within twelve (12) months of the injury or surgical treatment.
- (5) Replacement of a full denture or bridgework if the replacement is made more than seven (7) years after the date of installation, unless:
  - (a) such replacement is made necessary by the initial extraction of an adjoining functional natural tooth; or
  - (b) the prosthesis, while in the oral cavity, has been damaged beyond repair as a result of a non-chewing injury while covered;
- (6) Repair or relines of dentures and bridgework[;
- (7) Implants, as an alternative to a fixed prosthetic, (limited to once in a lifetime per site). The cost of the fixed prosthetic will be applied to the total value of the implant and implant-related procedures, not to exceed the cost of the fixed prosthetic:
  - (a) the surgical placement of endosteal implant body including healing cap, where the bone and soft tissues are sound and healthy;
  - (b) implant supported prosthetics;

- (c) eposteal and transosteal implants will be covered at the cost of the endosteal implant (if performed, member is responsible for additional fees);
- (d) bone grafting and tooth extractions, provided the work is done while this coverage is in force;
- (e) implant maintenance].

### **EXCLUSIONS ON SUPPLEMENTAL DENTAL PLAN**

The following exclusions are not Covered Services. No payments will be made by Us for these services:

- (1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;
- (2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
- (3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
- (4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;
- (5) Services and supplies begun and not completed prior to the patient's effective date, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
- (6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
- (7) Pulp capping, if in conjunction with the installation of inlays, onlays or crowns and fillings or other lab fabricated restorations; including but not limited to inlays, onlays and crowns, preventative tests and examinations diagnostic casts and oral cancer screenings, and expenses incurred for sedative fillings, including charges for prescribed drugs, pre-medication or analgesia;
- (8) The initial installation of a prosthetic device (a fixed bridge, implant, or denture), including crowns and inlays which form abutments, to replace teeth missing before You were covered under the Policy, except when it also replaces a tooth that is extracted while covered unless such installation commences after You have remained continuously covered under this plan for at least three years immediately prior to the date such installation commences;
- (9) Implants, implant services and implant supported prosthetics[ are not covered for patients under the age of sixteen (16)];
- (10) Expenses incurred for veneers and related procedures;
- (11) Replacement of a lost or stolen or discarded prosthetic device;
- (12) Adjustment, repairs or relines of prostheses for a period of one (1) year from initial placement if the prostheses were paid for under this plan;
- (13) Expenses incurred for a core buildup will only be considered in conjunction with a crown;
- (14) If multiple endodontic treatments are necessary on the same tooth within a period of one (1) year, the allowance will be made for only one (1) procedure;
- (15) X-rays are considered an integral part of the endodontic procedure rather than a separate service and are therefore not eligible for benefits;
- (16) The extraction of immature erupting third molars and non-pathologic, asymptomatic third molar extractions;
- (17) Expenses for gross debridement allowed one time at the beginning of the periodontal treatment plan prior to pocket depth charting;

- (18) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
- (19) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are a Covered Dental Expense on this Plan;
- (20) Surgical procedures incidental to orthodontic treatment, including but not limited to, extraction of teeth solely for orthodontic reasons, exposure of impacted teeth, correction of micrognathia or macrognathia, or repair of cleft palate;
- (21) Charges for service provided for temporomandibular joint dysfunction (TMJ);
- (22) Expenses incurred for congenital or developmental malformations;
- (23) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
- (24) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits;
- (25) Chemotherapeutic agents and any other experimental procedures;
- (26) Charges in excess of Usual, Reasonable and Customary charges or in excess of the Calendar Year Maximum amount stated in the "Schedule of Dental Benefits" section of this Plan, or in excess of the Preferred Provider Fee Schedule;
- (27) Expenses that are applied toward satisfaction of a Deductible, if any;
- (28) Services and supplies performed outside of the United States of America;
- (29) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, Your lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;
- (30) Expenses for services for which You would not legally have to pay if there were no insurance;
- (31) Services not completed on or before the date of termination;
- (32) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
- (33) Any service or procedure not commonly found within the scope of practice by a licensed dentist. Such procedures are identified within the current Common Dental Terminology (CDT Codes) published by the American Dental Association;
- (34) Expenses incurred for services covered on a pediatric only dental plan.]

### **PART 3 - LIMITATIONS AND COST SHARING**

#### **ACCESS TO CARE**

##### **Using a Network Provider:**

BEST Life offers Insureds the option to save on out-of-pocket costs when care is provided by a Network Provider. A listing of General Dentists and Specialists is available. To find a Network Provider, please refer to the Network information provided on the ID Card.

##### **How to Select a Dentist:**

Insureds on this Plan may obtain dental services from any licensed dental professional in the United States. To use the Plan, Insureds may directly contact the dentist of their choice and make an appointment. Insureds are advised to bring their ID Card to their appointment. The dentist may require a copy of the Insured's ID Card to confirm eligibility on this Plan.

##### **How to Obtain a Referral:**

A dentist may determine that an Insured requires treatment from a dental provider that specializes in a type of dentistry (Specialist). The Insured does not need to contact BEST Life for a referral. The Insured can directly contact the Specialist to make an appointment. The Specialist may require

information from the Insured's dentist to determine a treatment plan and may contact the dentist directly.

### **ADVANCE NOTICE OF DENTAL TREATMENT**

Subscriber or Insured should submit Advance Notice of Dental Treatment before treatment commences in order to obtain Predetermination of Covered Services, including services that are medically necessary. If dental services are performed without such Predetermination, We reserve the right to deny any claim submitted with respect to such Covered Services; provided however, that predetermination is not required for:

- (1) Covered Services for which the related expense is less than \$500 during any course of treatment ("course of treatment" means one treatment or one of a planned series of treatments resulting from dental examination);
- (2) Emergency treatment; or
- (3) Oral examination and prophylaxis.

Predetermination is required for the following dental services for children:

- (1) Medically necessary services or supplies;
- (2) Panoramic film for children under age six (6);
- (3) Periodontal scaling and root planing;
- (4) Occlusal orthotic devices;
- (5) Appliance therapy;
- (6) Orthodontia, including preorthodontic treatment visit.

Predetermination is required for the following dental services for adults and children 19 or older:

- (1) Crowns, Anterior, except with posts or root canal;
- (2) Crowns, 2 or more Posterior, except with posts or root canal;
- (3) Inlays or Onlays, 2 or more, except with posts or root canal;
- (4) Laminates;
- (5) Anterior composites;
- (6) 2 or more multiple surfaces;
- (7) Bridges – initial or replacement;
- (8) Eligible partial dentures – initial or replacement;
- (9) Periodontal surgery over \$500;
- (10) Full bony impactions, 2 or more.

We will have thirty (30) days to furnish the provider with an Explanation of Benefits demonstrating whether the proposed treatment will be a Covered Service under this Policy.

### **DEDUCTIBLES**

**Annual Deductible:** The Annual Deductible shown in the Schedule of Dental Benefits will apply separately to each Insured. Each Insured must accumulate eligible expenses equal to the deductible amount.

### **ALTERNATIVE PROCEDURES**

If more than one treatment plan exists for a dental procedure, covered dental expenses will be based on

the least expensive procedure that will produce a result that meets professionally recognized standards. If the Insured's provider elects the more expensive treatment, the Insured or Subscriber shall be responsible for any charges that are greater than the covered expense for the less expensive treatment.

#### **PART 4 - DEFINITIONS**

**Annual:** The twelve (12) month period beginning on the effective date of the Certificate and ending on the termination date of the Certificate. The Annual time frame will be applied to the Deductible and the Annual Maximum amount.

**Annual Deductible:** The amount each Insured must satisfy before Benefits are payable by Us. To satisfy the Annual Deductible, the Insured must accumulate expenses for Covered Services equal to the Deductible amount shown on the Schedule of Benefits.

**Annual Maximum:** The maximum amount BEST Life will reimburse for covered services during a twelve (12) month period for each Insured person. Once the full Annual Maximum amount has been paid, no additional services will be reimbursed for the remainder of that year. The

**Child:** A person under the age of twenty-six (26) years. Depending on the Child's age, an enrolled Child may be covered either on the Pediatric Dental Plan or Supplemental Dental Plan as follows:

1. A Child who is less than nineteen (19) years of age on the coverage effective date will be covered on the Pediatric Dental Plan until that Child is nineteen (19) years of age on the renewal date;
2. A Child who is between nineteen (19) and twenty-six (26) years of age on the coverage effective date will be covered on the Supplemental Dental Plan until that Child no longer meets the definition of an Eligible Dependent.

**Coinsurance:** The amount of an expense for a Covered Service that we will pay once the deductible is satisfied.

**Covered Service:** A service or supply listed as a Covered Service and not otherwise limited or excluded by this Certificate. A Covered Service must be provided by a doctor of medical dentistry or a doctor of dental surgery, or a dentist.

**Eligible Dependent:** Means:

- (1) Your lawful spouse or domestic partner and
- (2) Your or Your spouse's or domestic partner's child or children, including a natural child, step-child, foster child, lawfully adopted child or child in the process of being adopted, from the date of placement, or any child for whom You have been granted legal custody, provided they are [less than][between 20 and] 26 years of age; or
- (3) A child named in a Qualified Medical Child Support Order will be considered a dependent.

"Eligible Dependent" also means a dependent child, who upon reaching the termination age, is unable to sustain employment because of a permanent mental or physical handicap and You notify Us in writing within thirty-one (31) days after the termination age, the child will continue to qualify as a dependent under this plan, provided You and the dependent child continue to be insured under this plan, and the child continues to be handicapped and dependent upon You for support. This shall not apply to a dependent child who is beyond the termination age on the date You become eligible for dependent insurance under this Policy.

**Family Deductible:** The Family Deductible is satisfied when each of three (3) covered members of Your family satisfy the Annual Deductible. Once the combined costs of services provided by covered members of Your family is equal to the Family Deductible amount, no additional Deductible will be required for other insured family members for the remainder of the Calendar Year.

**Emergency Care:** A dental emergency where an acute disorder of oral health requires dental and/or medical attention, including broken, loose, or evulsed teeth caused by traumas; infections and inflammations of the soft tissues of the mouth; and complications of oral surgery, such as dry tooth socket.

**Grace Period:** A Grace Period of thirty-one (31) days from the due date will be allowed for payment of each premium after the first. This coverage will remain in effect during the Grace Period; provided the premium is paid before the end of the Grace Period.

**Insured:** The Subscriber or any Eligible Dependent of a Subscriber who is enrolled in and covered under the Policy.

**Medically Necessary:** The determination process that may include, and not limited to, the evaluation of the effectiveness and benefit of a dental service or supply for the individual patient based on scientific evidence considerations, up-to-date and consistent professional standards of care, convincing expert opinion and a comparison to alternative interventions, including interventions, and the cost effectiveness of such service or supply. Medical necessity may be obtained by applying an Advance Notice of Treatment.

**Network Provider:** A dental care professional that is contracted with Us and is part of the Network shown on the Schedule of Benefits.

**Out-of-Network Provider:** A dental care professional that is not a Network Provider.

**Policy Effective Date:** The date shown on the Statement of Coverage as the Policy Effective Date.

**Statement of Coverage:** The proof of insurance issued to an individual insured under the Policy, outlining the insurance benefits and principle provisions applicable to the member.

**Subscriber:** The primary insured person as shown on the Statement of Coverage.

**Usual, Reasonable and Customary:** The charge for health care that is consistent with the average rate or charge for identical or similar services in a certain geographical area.

**You or Your:** Means the Insured.

## **PART 5 - COVERAGE EFFECTIVE AND TERMINATION DATES**

### **EFFECTIVE DATE**

**Coverage:** The Insured's coverage will take effect on the Insured's Effective Date as shown on the Statement of Coverage.

### **TERMINATION OF INSURANCE**

The Insured's coverage will stop on the earliest of the following dates:

- (1) the last day of the month in which the Subscriber stops being a member of the Association;
- (2) the last day of the month in which the Insured stops being a member of a class eligible for insurance under this plan;
- (3) the last day of the month in which the Subscriber requests coverage be cancelled;
- (4) the day before the due date of any premium that remains unpaid at the end of the Grace Period;
- (5) the date the Policy terminates;
- (6) the last day of the month in which an Insured stops meeting the definition of Eligible Dependent; or
- (7) the day the Insured moves outside of the service area for Insured's selected network. Insured may request a plan change if Insured moves within an area where an alternate plan is available.

BEST Life will notify Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of this insurance coverage.

## **PART 6 –PREMIUM PROVISIONS**

**Premium Payments:** Renewal premiums are payable to the Company. The payment of any premium shall not continue this Policy in force beyond the next premium due date, except as provided in the Grace Period provision.

**Changes in Premiums:** We may change the amount of the required premium due from the Policyholder by giving the Policyholder at least sixty (60) days advance written notice. During the first 12 months, We will not change the amount of the required premium.

**Grace Period:** This Policy has a thirty-one (31) day Grace Period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following thirty-one (31) days. During the Grace Period, this Policy will remain in force. If the required premium is not paid by the end of this Grace Period, this Policy will lapse as of the end of the Grace Period.

**Reinstatement:** If any renewal premium is not paid by the end of the Grace Period, coverage under this Policy will be terminated. However, BEST Life will reinstate this Policy, without requiring an application for reinstatement, as long as premium is paid for at least the sixty (60) days prior to the date of reinstatement. The reinstated Policy will cover only loss resulting from an accidental injury sustained after the date of reinstatement and loss due to sickness beginning ten (10) days after reinstatement. In all other respects the insured and BEST Life shall have the same rights as they had under the Policy immediately before the due date of the defaulted premium, subject to conditions and provisions of the Policy.

## **PART 7 – GENERAL PROVISIONS**

**Clerical Error:** Clerical error by the Policyholder shall not invalidate insurance otherwise validly in force nor continue insurance otherwise validly terminated.

**Third Party Responsibility:** If an Insured is injured or becomes ill through the act or omission of another person, to the extent that the Insured recovers medical expenses for the same Injury or Illness from a third party or its insurer, We will be entitled to a repayment of any remuneration in excess of benefits paid under the Policy due to the same Injury or Illness, and after the Insured is fully compensated for his or her loss. We may file a lien for such repayment. Upon request, the Insured must complete and return the required forms to Us.

The repayment agreement will be binding upon the Insured, or the legal representative of a minor or incompetent, whether:

- (1) the payment received from the third party, or its insurer, is the result of:
  - legal judgment;
  - an arbitration award;
  - a compromise settlement;
  - any other arrangements; or
- (2) the third party or its insurer had admitted liability for the payment; or
- (3) the medical expenses are itemized in the third party payment.

**Entire Contract; Changes:** The Policy, including the endorsements, certificates, riders, application and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions. We will consider any statement made by the Insured or the Policyholder, in the absence of fraud, as a representation and not a warranty.

**Underwriting Decisions:** If, for any reason, We cannot accept Your application for coverage, We will communicate Our decision to You in writing with the reasons supporting Our decision.

**Notification to Insureds:** BEST Life will notify Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of your insurance, a change in your premium, a change in eligibility or a change in your benefits.

**Right to Contest:** After this Policy has been in force for a period of two (2) years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application. No claim for loss incurred or disability (as defined in the Policy) commencing after two (2) years from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Policy.

**Notice of Claim:** We must receive written notice within twenty (20) days after a claim starts or as soon as reasonably possible. The notice shall be sent to BEST Life and Health Insurance Company at [2505 McCabe Way, Irvine, California 92614] or given it to Our agent.

**Claim Forms:** When We receive a notice of claim, We will send forms for filing the claim. If the Subscriber or Insured do not receive these forms within fifteen (15) days, the Subscriber or Insured may send Us a written statement to satisfy this requirement. This statement should include the nature and extent of the claim and be sent to Us within the time stated in the Proof of Loss provision.

**Proof of Loss:** We must receive written proof of loss within ninety (90) days of a claim. If it is not possible for proof to be provided within the ninety (90) days, We will not deny a claim for this reason if We receive the proof as soon as possible. In any event, We must receive proof no later than one year from the time specified, unless Subscriber is legally incapacitated.

**Time of Payment of Claims:** Indemnities payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this Policy



provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

**Payment of Claims:** All payments will be made to Subscriber or Insured's provider.

**Legal Actions:** A legal action may not be brought against Us before sixty (60) days, or after three (3) years, from the date written proof of loss is required to be given.

**Time Limit on Certain Defenses:** After this Policy has been in force for two (2) years, We will not use any statements made in the application of the Policyholder to void the Policy. After an Insured Person has been covered under this Policy for two (2) years, We will not use any statement made in the Insured Person's enrollment form to defend a claim.

**Misstatement of Age:** If the age of any individual covered under the Policy has been misstated, there shall be an adjustment of premium for the Policy so that there shall be paid to Us the premium for the coverage of such individual at his or her correct age, and the amount of the insurance coverage shall not be affected.

**Worker's Compensation:** The Policy is not in lieu of and does not affect any requirement for coverage by Worker's Compensation Insurance.

**Conformity with State Statutes:** Any provisions of the Policy which are in conflict with the statutes of the state in which the Policy was issued or delivered will be changed to conform to such laws.

**Waiver of Rights:** If We fail to enforce any provision of the Policy, such failure will not affect Our right to do so at a later date, nor will it affect Our right to enforce any other provision of the Policy.

**Inspection of Policy:** The Policy is in the possession of the Policyholder. It may be inspected at any time during business hours at the office of the Policyholder.

**Duty to Cooperate:** As a condition precedent to the payment of benefits hereunder, the Subscriber and Insured are required to cooperate with Us by providing all information reasonably required to accurately process a claim. Any failure to provide necessary information may result in a denial of benefits for the claim.

## **PART 8 – FILING A DENTAL CLAIM**

**HOW TO FILE A CLAIM:** Claim forms may be obtained from [the BEST Life website located at [www.bestlife.com](http://www.bestlife.com), click on "Forms"].

Submit claims to [BEST Life and Health Insurance Company], [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

For questions about a claim payment, contact BEST Life's Customer Service at [1-800-433-0088 or at [cs@bestlife.com](mailto:cs@bestlife.com), Monday through Friday, 7 am to 5 pm Pacific Time].

**CLAIMS DENIAL PROCEDURE:** Any denial of a claim for Benefits will be explained in writing. The explanation will include (a) the specific reason for the denial, (b) reference to the plan provision upon

which the denial was based, (c) a description of any additional information that might be required to provide and an explanation of why it is needed, and (d) an explanation of the plan's claim review procedure.

**APPEALING THE DENIAL OF A CLAIM:** You or an authorized representative You appoint to assist or represent You, may appeal any denial of a claim, in whole or in part, for Benefits by filing a written request for a review. The request must include all reasons You believe the initial decision was incorrect and all documentation supporting Your appeal, to BEST Life and Health Insurance Company, Attn: Appeals, [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

A request for a review must be filed within one-hundred and eighty (180) days after the date on which we issue the written notice of denial of a claim. BEST Life and Health Insurance Company will provide an appeal determination not later than sixty (60) days after receipt of a request for review. If there are special circumstances, the decision will be made as soon as possible, but no later than fifteen (15) days after receipt of the request for review. The appeal determination will be in writing and will include specific reasons for the decision. This decision shall also include specific references to the Policy provisions on which the decision was based.

**Underwritten by BEST Life and Health Insurance Company**

# Individual Insurance Policy

## Dental PPO Plan



[2505 McCabe Way  
Irvine, California 92614]

**Notice to Buyer: This Policy provides dental coverage only.**

**BEST Life and Health Insurance Company**  
[2505 McCabe Way  
Irvine, California 92614]

A STOCK COMPANY  
(Herein called the Company)

**BEST Life and Health Insurance Company ("BEST Life")** is issuing this Policy in consideration of the accuracy of representations made in Your application and Your payment of premiums for Policy coverage.

**READ YOUR POLICY CAREFULLY:** This Policy is a legal contract between You (owner of this Policy) and Us.

**GOVERNING JURISDICTION:** The Policy is issued in the State of Tennessee. It shall be construed in accordance with the laws of the issuing State.

**NOTICE OF TEN DAY RIGHT TO EXAMINE:** We want You to fully understand and be satisfied with the insurance coverage. If for any reason You are not satisfied, You may return this Policy to Your agent or to Our home office within ten (10) days of receipt and Your premium will be fully refunded. Coverage will then be void retroactive to the Insurance Effective Date.

**RENEWAL AND PREMIUM PAYMENT PROVISIONS:** You may renew this Policy for additional coverage periods by paying the premium when due or within the Grace Period until the Insureds reach age [19][65]. Each period of coverage runs from premium due date to premium due date. We reserve the right to change premiums. Any such change will be made according to the table of premium rates that will apply to all policies with the same form and class in Your State. All future renewal premiums will be based on Your original issue age. We will notify You of any premium rate increase at least sixty (60) days in advance. We cannot cancel this Policy while it is in force.

**IN WITNESS WHEREOF,** We have caused this Policy to be signed by Our President and Our Secretary. This Policy takes effect at 12:01 a.m. at Your residence on its Effective Date. This Policy terminates at 12:01 a.m. on the date any renewal premium is due and not paid, subject to the Grace Period.

[



**President**

II



**Secretary**

**Dental PPO Insurance Policy**

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**This Policy Is Not Valid  
Unless There Is a Complete Statement of Coverage**

**Statement of Coverage**

**DENTAL**

**INSURANCE SUBSCRIBER NAME:** [JOHN D. DOE]  
**POLICY EFFECTIVE DATE:** [01/01/2014]

**INSURED NAME(S) AND EFFECTIVE DATE(S):**

[JANE DOE 01/01/2014]  
[JON DOE 01/01/2014]

**[PLAN:** [PPO HIGH]  
**DEDUCTIBLE:** [\$50]  
**ANNUAL MAXIMUM:** [\$1,000]

**PEDIATRIC DENTAL PLAN:** [PPO HIGH]  
**DEDUCTIBLE:** [\$50]  
**OUT OF POCKET MAXIMUM:** [\$700]]

**POLICY NO.:** [XXXXXXXXXX]

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## PART 1 - SCHEDULE OF BENEFITS

This Policy is made valid on the effective dates shown for the listed Insureds on the Statement of Coverage.

Covered Services received by Insured from a Network Provider are reimbursed at the Network Provider's contracted Fee Schedule. Covered Services received by Insured from an Out-of-Network Provider are reimbursed at the [80th or 90th] percentile of a Usual, Reasonable and Customary schedule. All Covered Services are subject to Cost Sharing as shown on this Schedule of Benefits.

### [Pediatric Dental Plan Schedule of Benefits For Children to Age 19]

	<b>[BEST Life Child Dental] [Plus] Pediatric Dental Plan</b>	
<b>Procedure Categories</b>	<b>In-Network [Network Name]</b>	<b>Out-of-Network</b>
<b>Out-of-Pocket Maximum</b>	\$700 for 1 Child \$1,400 for 2 or more Children	\$700 for 1 Child \$1,400 for 2 or more Children
<b>Annual Deductible</b> – Applies to Preventive[,] [services received Out-of-Network as well as] Basic and Major services received In-Network or Out-of-Network	\$[0][50]	\$[50][100]
<b>Diagnostic &amp; Preventive Services Coinsurance</b> – Exams, cleanings, sealants, fluoride treatment, x-rays	100%	[90][60]%
<b>Basic Services Coinsurance</b> – Fillings	[70][55]%	[60][40]%
<b>Major Services Coinsurance</b> – Crowns & casts, prosthodontics, endodontics, periodontics, oral surgery	[50][35]%	[40][20]%
<b>Orthodontic Services Coinsurance</b> (Medically necessary Orthodontic Services only)	50% [24 Month Wait]	50% [24 Month Wait]

**[Dental Plan Schedule of Benefits  
For Adults and Dependent Children between 19 and 26]**

	<b>[BESTOne Dental] [Advantage][Plus][Basic] Supplemental Plan</b>	
<b>Benefits Description</b>	<b>In-Network [Network]</b>	<b>Out-of-Network</b>
<b>Annual Maximum</b>	\$[500 – 3,500]	
<b>Annual Deductible</b> (Applies to Basic and Major) – 3 Deductible Maximum per Family	[\$0-100]	
<b>Preventive Care Services</b> Routine oral exam, cleanings, X-rays	[100-70]%	[100-70]%
<b>Basic Services</b> Fillings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology	[90-50]%	[80-20]%
<b>Major Services</b> Crowns & gold fillings, inlays, onlays & pontics, [implants,] fixed bridges, complete & partial dentures	[60-0]%	[50-0]%
<b>[Major Services Waiting Period]</b>	12 Months]	
<b>Endodontic Services</b>	[Basic][Major]	
<b>Periodontic Services</b>	[Basic][Major]	
<b>Oral Surgery Services</b>	[Basic][Major]	
<b>Usual and Customary Reimbursement</b>	Fee Schedule	[80 <sup>th</sup> ][90 <sup>th</sup> ] Percentile

**PART 2 - BENEFITS AND EXCLUSIONS**

**COVERED SERVICES ON  
PEDIATRIC DENTAL PLAN**

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Policy.

**Class I – Preventive and Diagnostic Procedures Include:**

- (1) Prophylaxis not more often than once every six (6) months;
- (2) Topical application of fluoride (excluding prophylaxis) not more often than twice every twelve (12) months;
- (3) Topical fluoride varnish not more often than twice every twelve (12) months;
- (4) Sealants not more often than once per tooth in a thirty-six (36) month period and limited to unrestored permanent molars for individuals under age nineteen (19);
- (5) Space maintainers, including re-cementation, for individuals under age nineteen (19) (excluding removal of fixed space maintainer);
- (6) Periodic oral evaluation not more often than once every six (6) months;
- (7) Limited oral evaluation (problem focused) not more often than once every six (6) months;
- (8) Comprehensive oral evaluation not more often than once every six (6) months;
- (9) Comprehensive periodontal evaluation not more often than once every six (6) months;
- (10) Intraoral complete X-rays or panoramic film not more often than once in a 60-month period;
- (11) Bitewing X-rays not more often than one set every six (6) months;
- (12) Single film intraoral periapical or occlusal;

- (13) Palliative treatment of dental pain (minor procedure);

**Class II – Basic Procedures Include:**

- (1) Amalgams, resin-based composites, re-cement inlays, re-cement crowns, protective restoration, pin retention;
- (2) Prefabricated stainless steel crowns not more often than once per tooth in a sixty (60) month period for individuals under age fifteen (15);
- (3) Therapeutic pulpotomy (excluding restoration) if a root canal is not performed within forty-five (45) days of the pulpotomy;
- (4) Partial pulpotomy for apexogenesis limited to permanent tooth with incomplete root development, if a root canal is not performed within forty-five (45) days of pulpotomy;
- (5) Pulpal therapy (excluding final restoration) once per tooth per lifetime, limited to primary incisor teeth for individuals up to age six (6), and limited to primary molars and cuspids for individuals up to age eleven (11);
- (6) Periodontal scaling and root planning, per quadrant, not more often than once every twenty-four (24) months;
- (7) Periodontal maintenance not more often than four in a twelve (12)-month period, combined with adult prophylaxis after the completion of active periodontal therapy;
- (8) Adjustment and repair of complete or partial dentures;
- (9) Rebase and reline not more often than once in a thirty-six (36) month period, six (6) months after initial installation;
- (10) Tissue conditioning;
- (11) Recement fixed partial denture
- (12) Fixed partial denture repair, by report;
- (13) Oral surgery:
  - a. extraction for erupted tooth or exposed root;
  - b. surgical removal of erupted tooth;
  - c. removal of impacted tooth;
  - d. removal of residual tooth roots;
  - e. coronectomy;
  - f. tooth reimplantation;
  - g. surgical access of unerupted tooth;
  - h. alveoloplasty;
  - i. removal of exostosis;
  - j. incision and drainage of abscess;
  - k. suture of recent small wounds up to five (5) cm
  - l. excision of pericoronal gingival;

**Class III – Major Procedures Include:**

- (1) Detailed and extensive oral evaluation;
- (2) Inlays, onlays, crowns, core buildup, including any pins, prefabricated post and core in addition to crown, limited to one per tooth every sixty (60) months;
- (3) Endodontics (root canal)
- (4) Gingivectomy or gingivoplasty, four (4) or more teeth not more often than once every thirty-six (36) months;
- (5) Gingival flap procedure, four (4) or more teeth not more often than once every thirty-six (36) months;
- (6) Osseous surgery, four (4) or more contiguous teeth or bounded teeth spaces per quadrant, not more often than once every thirty-six (36) months;
- (7) Full mouth debridement limited to one (1) per lifetime;

- (8) Complete and partial dentures, including abutments, pontics, onlays, retainers and crowns, not more often than once every sixty (60) months (excludes interim dentures);
- (9) Implants and implant services once every sixty (60) months only if medically necessary;
- (10) Occlusal guard not more often than once in twelve (12) months for individuals thirteen (13) and older with predetermination only;
- (11) General anesthesia or IV sedation;
- (12) Consultation by dentist or physician other than the dentist providing treatment;
- (13) Therapeutic drug injection with predetermination;
- (14) Treatment of post-surgical complications with predetermination.

[**Note:** Unless the twenty-four (24) month waiting period requirement for Medically Necessary Orthodontic services has been met, the services below are not covered benefits for any treatment that began during the twenty-four (24) month period immediately following Your effective date of coverage.]

**Class IV – Medically Necessary Orthodontic Procedures Include:**

- (1) For orthodontia services associated with the repair of cleft palate and palate or other severe craniofacial defects or injury for which the function of speech, swallowing or chewing is restored;
- (2) Requires predetermination; and
- (3) Coverage includes diagnosis, treatment plan, anticipated treatment time and cost estimate.

**EXCLUSIONS ON  
PEDIATRIC DENTAL PLAN**

The following exclusions are not Covered Services. No payments will be made by Us for these services:

- (1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;
- (2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
- (3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
- (4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;
- (5) Services and supplies started and not completed before the patient was covered under this Plan, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
- (6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
- (7) Space maintainers;
- (8) Sealants if re-sealed within a five (5) year period;
- (9) Retreatment of a previous root canal or apicoectomy/periradicular surgery;
- (10) Elective tooth extractions;
- (11) Separate payments for open and drain palliative procedure when the root canal is completed on the same date of service;
- (12) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are defined as a Covered Dental Expense;
- (13) Charges in excess of Usual, Reasonable and Customary charges amount stated in the "Schedule

- of Benefits" section of this Plan, or in excess of the Preferred Provider Fee Schedule;
- (14) Charges for service provided for temporomandibular joint dysfunction (TMJ);
  - (15) Expenses incurred for congenital or developmental malformations, except as defined as a Covered Orthodontic Expense;
  - (16) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits, except as defined as a Covered Orthodontic Expense;
  - (17) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
  - (18) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, the patient's lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;
  - (19) Expenses for services for which the patient would not legally have to pay if there were no insurance, unless mandated by the State;
  - (20) Services not completed on or before the date of termination;
  - (21) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
  - (22) Expenses that are applied toward satisfaction of a Deductible, if any;
  - (23) Any service or procedure not commonly found within the scope of practice by a licensed dentist;
  - (24) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
  - (25) Chemotherapeutic agents and any other experimental procedures;
  - (26) Expenses incurred for veneers and related procedures;
  - (27) Services and supplies performed outside of the United States of America.

#### **[COVERED SERVICES ON SUPPLEMENTAL DENTAL PLAN**

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Policy.

##### **CLASS I - Preventive Dental Procedures include:**

- (1) Routine oral examination and diagnosis not more often than twice every twelve (12) months per individual;
- (2) Bitewing x-rays not more often than once every twelve (12) months per individual;
- (3) Full mouth x-rays or panoramic films are limited to once every five (5) years; any combination of eight (8) or more x-rays (including but not limited to bitewings or periapicals/intraorals) will be combined into a full mouth x-ray series;
- (4) Prophylaxis not more often than once every six (6) months per individual.

##### **CLASS II - Basic Dental Procedures include:**

- (1) Pathology;
- (2) All fillings other than lab fabricated restorations (composite fillings limited to permanent anterior and posterior teeth);
- (3) Emergency palliative treatment;
- (4) Limited oral exam not more than once every six months;
- (5) Simple extraction, excluding orthodontic extractions unless a orthodontic benefits are a Covered Dental Expense on this Plan;

- (6) Surgical extraction, including impaction:
  - (a) erupted tooth;
  - (b) soft tissue impaction;
  - (c) partial bony impaction;
  - (d) complete bony impaction;
- (7) General anesthesia or intravenous sedation when required for complex oral surgical procedures (partial and complete bony impacted extractions only);
- (8) Periodontics (tissues and gums);
- (9) Periodontal exam (not in addition to a routine oral exam);
- (10) Periodontal maintenance (limited to once every six (6) months per individual following active periodontal treatment) and not on the same visit as a routine prophylaxis;
- (11) Periodontal scaling and root planing (limited to once every 36 months and to two (2) quadrants per visit, and not in addition to a routine prophylaxis);
- (12) Endodontics (pulp capping and root canal); and
- (13) Oral surgery:
  - (a) root recovery (surgical removal of residual root);
  - (b) oral antral fistula closure;
  - (c) removal of a dentigerous or odontogenic cyst;
  - (d) incision and drainage of an abscess;
  - (e) removal of lateral exostosis;
  - (f) frenulectomy.

[**Note:** Unless the twelve (12) month waiting period requirement for Major Dentistry services has been met, the services below are not covered benefits for any treatment that began during the twelve (12) month period immediately following Your effective date of coverage.]

**CLASS III - Major Dental Procedures include:**

- (1) Inlays, onlays, crowns and other lab fabricated restorations (not including veneers);
- (2) Porcelain, porcelain fused to metal, or full gold crowns on permanent teeth;
- (3) Full or partial dentures or fixed bridgework or adding teeth to an existing denture, if required because of loss of functional natural teeth while the person is covered for this Benefit. The work must be done within twelve (12) months after the extraction and while this coverage is in force;
- (4) Replacement or alteration of full or partial dentures or fixed bridgework caused by the following while coverage is in force:
  - (a) accidental injury requiring oral surgical treatment, or
  - (b) oral surgical treatment involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus or redundant tissue, provided the replacement or alteration is done within twelve (12) months of the injury or surgical treatment.
- (5) Replacement of a full denture or bridgework if the replacement is made more than seven (7) years after the date of installation, unless:
  - (a) such replacement is made necessary by the initial extraction of an adjoining functional natural tooth; or
  - (b) the prosthesis, while in the oral cavity, has been damaged beyond repair as a result of a non-chewing injury while covered;
- (6) Repair or reline of dentures and bridgework[;
- (7) Implants, as an alternative to a fixed prosthetic, (limited to once in a lifetime per site). The cost of the fixed prosthetic will be applied to the total value of the implant and implant-related procedures, not to exceed the cost of the fixed prosthetic:
  - (a) the surgical placement of endosteal implant body including healing cap, where the bone and soft tissues are sound and healthy;
  - (b) implant supported prosthetics;

- (c) eposteal and transosteal implants will be covered at the cost of the endosteal implant (if performed, member is responsible for additional fees);
- (d) bone grafting and tooth extractions, provided the work is done while this coverage is in force;
- (e) implant maintenance].

### **EXCLUSIONS ON SUPPLEMENTAL DENTAL PLAN**

The following exclusions are not Covered Services. No payments will be made by Us for these services:

- (1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;
- (2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
- (3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
- (4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;
- (5) Services and supplies begun and not completed prior to the patient's effective date, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
- (6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
- (7) Pulp capping, if in conjunction with the installation of inlays, onlays or crowns and fillings or other lab fabricated restorations; including but not limited to inlays, onlays and crowns, preventative tests and examinations diagnostic casts and oral cancer screenings, and expenses incurred for sedative fillings, including charges for prescribed drugs, pre-medication or analgesia;
- (8) The initial installation of a prosthetic device (a fixed bridge, implant, or denture), including crowns and inlays which form abutments, to replace teeth missing before You were covered under the Policy, except when it also replaces a tooth that is extracted while covered unless such installation commences after You have remained continuously covered under this plan for at least three years immediately prior to the date such installation commences;
- (9) Implants, implant services and implant supported prosthetics[ are not covered for patients under the age of sixteen (16)];
- (10) Expenses incurred for veneers and related procedures;
- (11) Replacement of a lost or stolen or discarded prosthetic device;
- (12) Adjustment, repairs or relines of prostheses for a period of one (1) year from initial placement if the prostheses were paid for under this plan;
- (13) Expenses incurred for a core buildup will only be considered in conjunction with a crown;
- (14) If multiple endodontic treatments are necessary on the same tooth within a period of one (1) year, the allowance will be made for only one (1) procedure;
- (15) X-rays are considered an integral part of the endodontic procedure rather than a separate service and are therefore not eligible for benefits;
- (16) The extraction of immature erupting third molars and non-pathologic, asymptomatic third molar extractions;
- (17) Expenses for gross debridement allowed one time at the beginning of the periodontal treatment plan prior to pocket depth charting;

- (18) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
- (19) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are a Covered Dental Expense on this Plan;
- (20) Surgical procedures incidental to orthodontic treatment, including but not limited to, extraction of teeth solely for orthodontic reasons, exposure of impacted teeth, correction of micrognathia or macrognathia, or repair of cleft palate;
- (21) Charges for service provided for temporomandibular joint dysfunction (TMJ);
- (22) Expenses incurred for congenital or developmental malformations;
- (23) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
- (24) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits;
- (25) Chemotherapeutic agents and any other experimental procedures;
- (26) Charges in excess of Usual, Reasonable and Customary charges or in excess of the Calendar Year Maximum amount stated in the "Schedule of Dental Benefits" section of this Plan, or in excess of the Preferred Provider Fee Schedule;
- (27) Expenses that are applied toward satisfaction of a Deductible, if any;
- (28) Services and supplies performed outside of the United States of America;
- (29) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, Your lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;
- (30) Expenses for services for which You would not legally have to pay if there were no insurance;
- (31) Services not completed on or before the date of termination;
- (32) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
- (33) Any service or procedure not commonly found within the scope of practice by a licensed dentist. Such procedures are identified within the current Common Dental Terminology (CDT Codes) published by the American Dental Association;
- (34) Expenses incurred for services covered on a pediatric only dental plan.]

### **PART 3 - LIMITATIONS AND COST SHARING**

#### **ACCESS TO CARE**

##### **Using a Network Provider:**

BEST Life offers Insureds the option to save on out-of-pocket costs when care is provided by a Network Provider. A listing of General Dentists and Specialists is available. To find a Network Provider, please refer to the Network information provided on the ID Card.

##### **How to Select a Dentist:**

Insureds on this Plan may obtain dental services from any licensed dental professional in the United States. To use the Plan, Insureds may directly contact the dentist of their choice and make an appointment. Insureds are advised to bring their ID Card to their appointment. The dentist may require a copy of the Insured's ID Card to confirm eligibility on this Plan.

##### **How to Obtain a Referral:**

A dentist may determine that an Insured requires treatment from a dental provider that specializes in a type of dentistry (Specialist). The Insured does not need to contact BEST Life for a referral. The Insured can directly contact the Specialist to make an appointment. The Specialist may require



information from the Insured's dentist to determine a treatment plan and may contact the dentist directly.

### **ADVANCE NOTICE OF DENTAL TREATMENT**

Subscriber or Insured should submit Advance Notice of Dental Treatment before treatment commences in order to obtain Predetermination of Covered Services, including services that are medically necessary. If dental services are performed without such Predetermination, We reserve the right to deny any claim submitted with respect to such Covered Services; provided however, that predetermination is not required for:

- (1) Covered Services for which the related expense is less than \$500 during any course of treatment ("course of treatment" means one treatment or one of a planned series of treatments resulting from dental examination);
- (2) Emergency treatment; or
- (3) Oral examination and prophylaxis.

Predetermination is required for the following dental services for children:

- (1) Medically necessary services or supplies;
- (2) Panoramic film for children under age six (6);
- (3) Periodontal scaling and root planing;
- (4) Occlusal orthotic devices;
- (5) Appliance therapy;
- (6) Orthodontia, including preorthodontic treatment visit.

Predetermination is required for the following dental services for adults and children 19 or older:

- (1) Crowns, Anterior, except with posts or root canal;
- (2) Crowns, 2 or more Posterior, except with posts or root canal;
- (3) Inlays or Onlays, 2 or more, except with posts or root canal;
- (4) Laminates;
- (5) Anterior composites;
- (6) 2 or more multiple surfaces;
- (7) Bridges – initial or replacement;
- (8) Eligible partial dentures – initial or replacement;
- (9) Periodontal surgery over \$500;
- (10) Full bony impactions, 2 or more.

We will have thirty (30) days to furnish the provider with an Explanation of Benefits demonstrating whether the proposed treatment will be a Covered Service under this Policy.

### **DEDUCTIBLES**

**Annual Deductible:** The Annual Deductible shown in the Schedule of Dental Benefits will apply separately to each Insured. Each Insured must accumulate eligible expenses equal to the deductible amount.

### **ALTERNATIVE PROCEDURES**

If more than one treatment plan exists for a dental procedure, covered dental expenses will be based on

the least expensive procedure that will produce a result that meets professionally recognized standards. If the Insured's provider elects the more expensive treatment, the Insured or Subscriber shall be responsible for any charges that are greater than the covered expense for the less expensive treatment.

#### **PART 4 - DEFINITIONS**

**Annual:** The twelve (12) month period beginning on the effective date of the Certificate and ending on the termination date of the Certificate. The Annual time frame will be applied to the Deductible and the Annual Maximum amount.

**Annual Deductible:** The amount each Insured must satisfy before Benefits are payable by Us. To satisfy the Annual Deductible, the Insured must accumulate expenses for Covered Services equal to the Deductible amount shown on the Schedule of Benefits.

**Annual Maximum:** The maximum amount BEST Life will reimburse for covered services during a twelve (12) month period for each Insured person. Once the full Annual Maximum amount has been paid, no additional services will be reimbursed for the remainder of that year. The

**Child:** A person under the age of twenty-six (26) years. Depending on the Child's age, an enrolled Child may be covered either on the Pediatric Dental Plan or Supplemental Dental Plan as follows:

1. A Child who is less than nineteen (19) years of age on the coverage effective date will be covered on the Pediatric Dental Plan until that Child is nineteen (19) years of age on the renewal date;
2. A Child who is between nineteen (19) and twenty-six (26) years of age on the coverage effective date will be covered on the Supplemental Dental Plan until that Child no longer meets the definition of an Eligible Dependent.

**Coinsurance:** The amount of an expense for a Covered Service that we will pay once the deductible is satisfied.

**Covered Service:** A service or supply listed as a Covered Service and not otherwise limited or excluded by this Certificate. A Covered Service must be provided by a doctor of medical dentistry or a doctor of dental surgery, or a dentist.

**Eligible Dependent:** Means:

- (1) Your lawful spouse or domestic partner and
- (2) Your or Your spouse's or domestic partner's child or children, including a natural child, step-child, foster child, lawfully adopted child or child in the process of being adopted, from the date of placement, or any child for whom You have been granted legal custody, provided they are [less than][between 20 and] 26 years of age; or
- (3) A child named in a Qualified Medical Child Support Order will be considered a dependent.

"Eligible Dependent" also means a dependent child, who upon reaching the termination age, is unable to sustain employment because of a permanent mental or physical handicap and You notify Us in writing within thirty-one (31) days after the termination age, the child will continue to qualify as a dependent under this plan, provided You and the dependent child continue to be insured under this plan, and the child continues to be handicapped and dependent upon You for support. This shall not apply to a dependent child who is beyond the termination age on the date You become eligible for dependent insurance under this Policy.

**Family Deductible:** The Family Deductible is satisfied when each of three (3) covered members of Your family satisfy the Annual Deductible. Once the combined costs of services provided by covered members of Your family is equal to the Family Deductible amount, no additional Deductible will be required for other insured family members for the remainder of the Calendar Year.

**Emergency Care:** A dental emergency where an acute disorder of oral health requires dental and/or medical attention, including broken, loose, or evulsed teeth caused by traumas; infections and inflammations of the soft tissues of the mouth; and complications of oral surgery, such as dry tooth socket.

**Grace Period:** A Grace Period of thirty-one (31) days from the due date will be allowed for payment of each premium after the first. This coverage will remain in effect during the Grace Period; provided the premium is paid before the end of the Grace Period.

**Insured:** The Subscriber or any Eligible Dependent of a Subscriber who is enrolled in and covered under the Policy.

**Medically Necessary:** The determination process that may include, and not limited to, the evaluation of the effectiveness and benefit of a dental service or supply for the individual patient based on scientific evidence considerations, up-to-date and consistent professional standards of care, convincing expert opinion and a comparison to alternative interventions, including interventions, and the cost effectiveness of such service or supply. Medical necessity may be obtained by applying an Advance Notice of Treatment.

**Network Provider:** A dental care professional that is contracted with Us and is part of the Network shown on the Schedule of Benefits.

**Out-of-Network Provider:** A dental care professional that is not a Network Provider.

**Policy Effective Date:** The date shown on the Statement of Coverage as the Policy Effective Date.

**Statement of Coverage:** The proof of insurance issued to an individual insured under the Policy, outlining the insurance benefits and principle provisions applicable to the member.

**Subscriber:** The primary insured person as shown on the Statement of Coverage.

**Usual, Reasonable and Customary:** The charge for health care that is consistent with the average rate or charge for identical or similar services in a certain geographical area.

**You or Your:** Means the Insured.

## **PART 5 - COVERAGE EFFECTIVE AND TERMINATION DATES**

### **EFFECTIVE DATE**

**Coverage:** The Insured's coverage will take effect on the Insured's Effective Date as shown on the Statement of Coverage.

### **TERMINATION OF INSURANCE**

The Insured's coverage will stop on the earliest of the following dates:

- (1) the last day of the month in which the Subscriber stops being a member of the Association;
- (2) the last day of the month in which the Insured stops being a member of a class eligible for insurance under this plan;
- (3) the last day of the month in which the Subscriber requests coverage be cancelled;
- (4) the day before the due date of any premium that remains unpaid at the end of the Grace Period;
- (5) the date the Policy terminates;
- (6) the last day of the month in which an Insured stops meeting the definition of Eligible Dependent; or
- (7) the day the Insured moves outside of the service area for Insured's selected network. Insured may request a plan change if Insured moves within an area where an alternate plan is available.

BEST Life will notify Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of this insurance coverage.

## **PART 6 – PREMIUM PROVISIONS**

**Premium Payments:** Renewal premiums are payable to the Company. The payment of any premium shall not continue this Policy in force beyond the next premium due date, except as provided in the Grace Period provision.

**Changes in Premiums:** We may change the amount of the required premium due from the Policyholder by giving the Policyholder at least sixty (60) days advance written notice. During the first 12 months, We will not change the amount of the required premium.

**Grace Period:** This Policy has a thirty-one (31) day Grace Period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following thirty-one (31) days. During the Grace Period, this Policy will remain in force. If the required premium is not paid by the end of this Grace Period, this Policy will lapse as of the end of the Grace Period.

~~**Termination of Policy:** We may terminate this Policy at any time following the first renewal date by giving the Policyholder written notice at least sixty (60) days in advance. The Policyholder may also terminate this Policy by giving Us written notice at least sixty (60) days before the intended termination date. This Policy will also terminate if the required premium is not paid by the Policyholder as provided in the Grace Period provision.~~

**Reinstatement:** If any renewal premium is not paid by the end of the Grace Period, coverage under this Policy will be terminated. However, BEST Life will reinstate this Policy, without requiring an application for reinstatement, as long as premium is paid for at least the sixty (60) days prior to the date of reinstatement. The reinstated Policy will cover only loss resulting from an accidental injury sustained after the date of reinstatement and loss due to sickness beginning ten (10) days after reinstatement. In all other respects the insured and BEST Life shall have the same rights as they had under the Policy immediately before the due date of the defaulted premium, subject to conditions and provisions of the Policy.

## **PART 7 – GENERAL PROVISIONS**

**Clerical Error:** Clerical error by the Policyholder shall not invalidate insurance otherwise validly in force nor continue insurance otherwise validly terminated.

**Third Party Responsibility:** If an Insured is injured or becomes ill through the act or omission of

another person, to the extent that the Insured recovers medical expenses for the same Injury or Illness from a third party or its insurer, We will be entitled to a repayment of any remuneration in excess of benefits paid under the Policy due to the same Injury or Illness, and after the Insured is fully compensated for his or her loss. We may file a lien for such repayment. Upon request, the Insured must complete and return the required forms to Us.

The repayment agreement will be binding upon the Insured, or the legal representative of a minor or incompetent, whether:

- (1) the payment received from the third party, or its insurer, is the result of:
  - legal judgment;
  - an arbitration award;
  - a compromise settlement;
  - any other arrangements; or
- (2) the third party or its insurer had admitted liability for the payment; or
- (3) the medical expenses are itemized in the third party payment.

**Entire Contract; Changes:** The Policy, including the endorsements, certificates, riders, application and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions. We will consider any statement made by the Insured or the Policyholder, in the absence of fraud, as a representation and not a warranty.

**Underwriting Decisions:** If, for any reason, We cannot accept Your application for coverage, We will communicate Our decision to You in writing with the reasons supporting Our decision.

**Notification to Insureds:** BEST Life will notify Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of your insurance, a change in your premium, a change in eligibility or a change in your benefits.

**Right to Contest:** After this Policy has been in force for a period of two (2) years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application. No claim for loss incurred or disability (as defined in the Policy) commencing after two (2) years from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Policy.

**Notice of Claim:** We must receive written notice within twenty (20) days after a claim starts or as soon as reasonably possible. The notice shall be sent to BEST Life and Health Insurance Company at [2505 McCabe Way, Irvine, California 92614] or given it to Our agent.

**Claim Forms:** When We receive a notice of claim, We will send forms for filing the claim. If the Subscriber or Insured do not receive these forms within fifteen (15) days, the Subscriber or Insured may send Us a written statement to satisfy this requirement. This statement should include the nature and extent of the claim and be sent to Us within the time stated in the Proof of Loss provision.

**Proof of Loss:** We must receive written proof of loss within ninety (90) days of a claim. If it is not possible for proof to be provided within the ninety (90) days, We will not deny a claim for this reason if We receive the proof as soon as possible. In any event, We must receive proof no later than one year from the

time specified, unless Subscriber is legally incapacitated.

**Time of Payment of Claims:** Indemnities payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this Policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

**Payment of Claims:** All payments will be made to Subscriber or Insured's provider.

**Legal Actions:** A legal action may not be brought against Us before sixty (60) days, or after three (3) years, from the date written proof of loss is required to be given.

**Time Limit on Certain Defenses:** After this Policy has been in force for two (2) years, We will not use any statements made in the application of the Policyholder to void the Policy. After an Insured Person has been covered under this Policy for two (2) years, We will not use any statement made in the Insured Person's enrollment form to defend a claim.

**Misstatement of Age:** If the age of any individual covered under the Policy has been misstated, there shall be an adjustment of premium for the Policy so that there shall be paid to Us the premium for the coverage of such individual at his or her correct age, and the amount of the insurance coverage shall not be affected.

**Worker's Compensation:** The Policy is not in lieu of and does not affect any requirement for coverage by Worker's Compensation Insurance.

**Conformity with State Statutes:** Any provisions of the Policy which are in conflict with the statutes of the state in which the Policy was issued or delivered will be changed to conform to such laws.

**Waiver of Rights:** If We fail to enforce any provision of the Policy, such failure will not affect Our right to do so at a later date, nor will it affect Our right to enforce any other provision of the Policy.

**Inspection of Policy:** The Policy is in the possession of the Policyholder. It may be inspected at any time during business hours at the office of the Policyholder.

**Duty to Cooperate:** As a condition precedent to the payment of benefits hereunder, the Subscriber and Insured are required to cooperate with Us by providing all information reasonably required to accurately process a claim. Any failure to provide necessary information may result in a denial of benefits for the claim.

## **PART 8 – FILING A DENTAL CLAIM**

**HOW TO FILE A CLAIM:** Claim forms may be obtained from [the BEST Life website located at [www.bestlife.com](http://www.bestlife.com), click on "Forms"].

Submit claims to [BEST Life and Health Insurance Company], [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

For questions about a claim payment, contact BEST Life's Customer Service at [1-800-433-0088 or at [cs@bestlife.com](mailto:cs@bestlife.com), Monday through Friday, 7 am to 5 pm Pacific Time].

**CLAIMS DENIAL PROCEDURE:** Any denial of a claim for Benefits will be explained in writing. The explanation will include (a) the specific reason for the denial, (b) reference to the plan provision upon which the denial was based, (c) a description of any additional information that might be required to provide and an explanation of why it is needed, and (d) an explanation of the plan's claim review procedure.

**APPEALING THE DENIAL OF A CLAIM:** You or an authorized representative You appoint to assist or represent You, may appeal any denial of a claim, in whole or in part, for Benefits by filing a written request for a review. The request must include all reasons You believe the initial decision was incorrect and all documentation supporting Your appeal, to BEST Life and Health Insurance Company, Attn: Appeals, [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

A request for a review must be filed within one-hundred and eighty (180) days after the date on which we issue the written notice of denial of a claim. BEST Life and Health Insurance Company will provide an appeal determination not later than sixty (60) days after receipt of a request for review. If there are special circumstances, the decision will be made as soon as possible, but no later than fifteen (15) days after receipt of the request for review. The appeal determination will be in writing and will include specific reasons for the decision. This decision shall also include specific references to the Policy provisions on which the decision was based.

**Underwritten by BEST Life and Health Insurance Company**



**BEST Life and Health Insurance Company**  
[2505 McCabe Way  
Irvine, California 92614]

**DENTAL POLICY – FORM: IFD-PPO-POL-0113TN**  
**REQUIRED OUTLINE OF COVERAGE**

- A. READ YOUR POLICY CAREFULLY!** This Outline of Coverage provides a very brief description of some of the important features of Your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both You and Us. It is, therefore, important that You **READ YOUR POLICY CAREFULLY**.
- B. Dental coverage** is designed to provide You with benefits described in the **BENEFITS** section below. The benefits described may be limited as outlined in the **LIMITATIONS** and **EXCLUSIONS** section.
- C. BENEFITS**

**SCHEDULE OF BENEFITS**

Covered Services received by Insured from a Network Provider are reimbursed at the Network Provider's contracted Fee Schedule. Covered Services received by Insured from an Out-of-Network Provider are reimbursed at the [80<sup>th</sup>][90<sup>th</sup>] percentile of a Usual, Reasonable and Customary schedule. All Covered Services are subject to Cost Sharing as shown on the Schedule of Benefits. Additional charges may not be covered by this Policy.

**Pediatric Dental Plan Schedule of Benefits**  
**For Children to Age 19**

[		
Procedure Categories	[BEST Life Child Dental] [Plus] High Pediatric Dental Plan	
	In-Network [Network Name]	Out-of-Network
<b>Out-of-Pocket Maximum</b>	\$700 for 1 Child \$1,400 for 2 or more Children	\$700 for 1 Child \$1,400 for 2 or more Children
<b>Annual Deductible</b> – Applies to Class I Services received Out-of-Network as well as Class II and III Services received In-Network or Out-of-Network	\$0	\$50
<b>Class I - Basic Services Coinsurance</b> [ – Exams, cleanings, sealants, fluoride treatment, x-rays]	100%	90%
<b>Class II - Intermediate Services Coinsurance</b> [ – Fillings]	70%	60%
<b>Class III - Major Services Coinsurance</b> [ – Crowns & casts, prosthodontics, endodontics, periodontics, oral surgery]	50%	40%

<b>Class IV - Medically Necessary Orthodontic Services Coinsurance</b>	50% [24 Month Wait]	50% [24 Month Wait]
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[

<b>[BEST Life Child Dental] Low Pediatric Dental Plan</b>		
<b>Procedure Categories</b>	<b>In-Network [Network Name]</b>	<b>Out-of-Network</b>
<b>Out-of-Pocket Maximum</b>	\$700 for 1 Child \$1,400 for 2 or more Children	\$700 for 1 Child \$1,400 for 2 or more Children
<b>Annual Deductible</b> – Applies to Class I, II and III services received In-Network or Out-of-Network	\$50	\$100
<b>Class I - Basic Services Coinsurance</b> [ – Exams, cleanings, sealants, fluoride treatment, x-rays]	100%	60%
<b>Class II - Intermediate Services Coinsurance</b> [ – Fillings]	55%	40%
<b>Class III - Major Services Coinsurance</b> [ – Crowns & casts, prosthodontics, endodontics, periodontics, oral surgery]	35%	20%
<b>Class IV - Medically Necessary Orthodontic Services Coinsurance</b>	50% [24 Month Wait]	50% [24 Month Wait]

]

**[Dental Plan Schedule of Benefits  
For Adults and Dependent Children between 19 and 26]**

<b>[BESTOne Dental] [Advantage][Plus][Basic] Supplemental Plan</b>		
<b>Benefits Description</b>	<b>In-Network [Network]</b>	<b>Out-of-Network</b>
<b>Annual Maximum</b>	\$[500 - 3,500]	
<b>Annual Deductible</b> (Applies to Basic and Major) – 3 Deductible Maximum per Family	[\$0-100]	
<b>Preventive Care Services</b> Routine oral exam, cleanings, X-rays	[100-70]%	[100-70]%
<b>Basic Services</b> Fillings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology	[90-50]%	[80-20]%

<b>Major Services</b> Crowns & gold fillings, inlays, onlays & pontics, [implants,] fixed bridges, complete & partial dentures	[60-0]%	[50-0]%
<b>[Major Services Waiting Period]</b>	12 Months]	
<b>Endodontic Services</b>	[Basic][Major]	
<b>Periodontic Services</b>	[Basic][Major]	
<b>Oral Surgery Services</b>	[Basic][Major]	
<b>Usual and Customary Reimbursement</b>	Fee Schedule	[80 <sup>th</sup> ][90 <sup>th</sup> ] Percentile

]

#### **D. LIMITATIONS**

#### **COVERED SERVICES ON PEDIATRIC DENTAL PLAN**

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Policy.

##### **Class I – Preventive and Diagnostic Procedures Include:**

- (1) Prophylaxis not more often than once every six (6) months;
- (2) Topical application of fluoride (excluding prophylaxis) not more often than twice every twelve (12) months;
- (3) Topical fluoride varnish not more often than twice every twelve (12) months;
- (4) Sealants not more often than once per tooth in a thirty-six (36) month period and limited to unrestored permanent molars for individuals under age nineteen (19);
- (5) Space maintainers, including re-cementation, for individuals under age nineteen (19) (excluding removal of fixed space maintainer);
- (6) Periodic oral evaluation not more often than once every six (6) months;
- (7) Limited oral evaluation (problem focused) not more often than once every six (6) months;
- (8) Comprehensive oral evaluation not more often than once every six (6) months;
- (9) Comprehensive periodontal evaluation not more often than once every six (6) months;
- (10) Intraoral complete X-rays or panoramic film not more often than once in a 60-month period;
- (11) Bitewing X-rays not more often than one set every six (6) months;
- (12) Single film intraoral periapical or occlusal;
- (13) Palliative treatment of dental pain (minor procedure);

##### **Class II – Basic Procedures Include:**

- (1) Amalgams, resin-based composites, re-cement inlays, re-cement crowns, protective restoration, pin retention;
- (2) Prefabricated stainless steel crowns not more often than once per tooth in a sixty (60) month period for individuals under age fifteen (15);
- (3) Therapeutic pulpotomy (excluding restoration) if a root canal is not performed within forty-five (45) days of the pulpotomy;
- (4) Partial pulpotomy for apexogenesis limited to permanent tooth with incomplete root development, if a root canal is not performed within forty-five (45) days of pulpotomy;
- (5) Pulpal therapy (excluding final restoration) once per tooth per lifetime, limited to primary incisor teeth for individuals up to age six (6), and limited to primary molars and cuspids for individuals up to age eleven (11);
- (6) Periodontal scaling and root planning, per quadrant, not more often than once every twenty-four (24) months;

- (7) Periodontal maintenance not more often than four in a twelve (12)-month period, combined with adult prophylaxis after the completion of active periodontal therapy;
- (8) Adjustment and repair of complete or partial dentures;
- (9) Rebase and reline not more often than once in a thirty-six (36) month period, six (6) months after initial installation;
- (10) Tissue conditioning;
- (11) Recement fixed partial denture
- (12) Fixed partial denture repair, by report;
- (13) Oral surgery:
  - a. extraction for erupted tooth or exposed root;
  - b. surgical removal of erupted tooth;
  - c. removal of impacted tooth;
  - d. removal of residual tooth roots;
  - e. coronectomy;
  - f. tooth reimplantation;
  - g. surgical access of unerupted tooth;
  - h. alveoloplasty;
  - i. removal of exostosis;
  - j. incision and drainage of abscess;
  - k. suture of recent small wounds up to five (5) cm
  - l. excision of pericoronal gingival;

**Class III – Major Procedures Include:**

- (1) Detailed and extensive oral evaluation;
- (2) Inlays, onlays, crowns, core buildup, including any pins, prefabricated post and core in addition to crown, limited to one per tooth every sixty (60) months;
- (3) Endodontics (root canal)
- (4) Gingivectomy or gingivoplasty, four (4) or more teeth not more often than once every thirty-six (36) months;
- (5) Gingival flap procedure, four (4) or more teeth not more often than once every thirty-six (36) months;
- (6) Osseous surgery, four (4) or more contiguous teeth or bounded teeth spaces per quadrant, not more often than once every thirty-six (36) months;
- (7) Full mouth debridement limited to one (1) per lifetime;
- (8) Complete and partial dentures, including abutments, pontics, onlays, retainers and crowns, not more often than once every sixty (60) months (excludes interim dentures);
- (9) Implants and implant services once every sixty (60) months only if medically necessary;
- (10) Occlusal guard not more often than once in twelve (12) months for individuals thirteen (13) and older with predetermination only;
- (11) General anesthesia or IV sedation;
- (12) Consultation by dentist or physician other than the dentist providing treatment;
- (13) Therapeutic drug injection with predetermination;
- (14) Treatment of post-surgical complications with predetermination.

[**Note:** Unless the twenty-four (24) month waiting period requirement for Medically Necessary Orthodontic services has been met, the services below are not covered benefits for any treatment that began during the twenty-four (24) month period immediately following Your effective date of coverage.]

**Class IV – Medically Necessary Orthodontic Procedures Include:**

- (1) For orthodontia services associated with the repair of cleft palate and palate or other severe

- craniofacial defects or injury for which the function of speech, swallowing or chewing is restored;
- (2) Requires predetermination; and
- (3) Coverage includes diagnosis, treatment plan, anticipated treatment time and cost estimate.

### **[COVERED SERVICES ON SUPPLEMENTAL DENTAL PLAN**

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Policy.

#### **CLASS I - Preventive Dental Procedures include:**

- (1) Routine oral examination and diagnosis not more often than twice every twelve (12) months per individual;
- (2) Bitewing x-rays not more often than once every twelve (12) months per individual;
- (3) Full mouth x-rays or panoramic films are limited to once every five (5) years; any combination of eight (8) or more x-rays (including but not limited to bitewings or periapicals/intraorals) will be combined into a full mouth x-ray series;
- (4) Prophylaxis not more often than once every six (6) months per individual.

#### **CLASS II - Basic Dental Procedures include:**

- (1) Pathology;
- (2) All fillings other than lab fabricated restorations (composite fillings limited to permanent anterior and posterior teeth);
- (3) Emergency palliative treatment;
- (4) Limited oral exam not more than once every six months;
- (5) Simple extraction, excluding orthodontic extractions unless a orthodontic benefits are a Covered Dental Expense on this Plan;
- (6) Surgical extraction, including impaction:
  - (a) erupted tooth;
  - (b) soft tissue impaction;
  - (c) partial bony impaction;
  - (d) complete bony impaction;
- (7) General anesthesia or intravenous sedation when required for complex oral surgical procedures (partial and complete bony impacted extractions only);
- (8) Periodontics (tissues and gums);
- (9) Periodontal exam (not in addition to a routine oral exam);
- (10) Periodontal maintenance (limited to once every six (6) months per individual following active periodontal treatment) and not on the same visit as a routine prophylaxis;
- (11) Periodontal scaling and root planing (limited to once every 36 months and to two (2) quadrants per visit, and not in addition to a routine prophylaxis);
- (12) Endodontics (pulp capping and root canal); and
- (13) Oral surgery:
  - (a) root recovery (surgical removal of residual root);
  - (b) oral antral fistula closure;
  - (c) removal of a dentigerous or odontogenic cyst;
  - (d) incision and drainage of an abscess;
  - (e) removal of lateral exostosis;
  - (f) frenulectomy.

**[Note:** Unless the twelve (12) month waiting period requirement for Major Dentistry services has been

met, the services below are not covered benefits for any treatment that began during the twelve (12) month period immediately following Your effective date of coverage.]

**CLASS III - Major Dental Procedures include:**

- (1) Inlays, onlays, crowns and other lab fabricated restorations (not including veneers);
- (2) Porcelain, porcelain fused to metal, or full gold crowns on permanent teeth;
- (3) Full or partial dentures or fixed bridgework or adding teeth to an existing denture, if required because of loss of functional natural teeth while the person is covered for this Benefit. The work must be done within twelve (12) months after the extraction and while this coverage is in force;
- (4) Replacement or alteration of full or partial dentures or fixed bridgework caused by the following while coverage is in force:
  - (a) accidental injury requiring oral surgical treatment, or
  - (b) oral surgical treatment involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus or redundant tissue, provided the replacement or alteration is done within twelve (12) months of the injury or surgical treatment.
- (5) Replacement of a full denture or bridgework if the replacement is made more than seven (7) years after the date of installation, unless:
  - (a) such replacement is made necessary by the initial extraction of an adjoining functional natural tooth; or
  - (b) the prosthesis, while in the oral cavity, has been damaged beyond repair as a result of a non-chewing injury while covered;
- (6) Repair or relines of dentures and bridgework[;
- (7) Implants, as an alternative to a fixed prosthetic, (limited to once in a lifetime per site). The cost of the fixed prosthetic will be applied to the total value of the implant and implant-related procedures, not to exceed the cost of the fixed prosthetic:
  - (a) the surgical placement of endosteal implant body including healing cap, where the bone and soft tissues are sound and healthy;
  - (b) implant supported prosthetics;
  - (c) eposteal and transosteal implants will be covered at the cost of the endosteal implant (if performed, member is responsible for additional fees);
  - (d) bone grafting and tooth extractions, provided the work is done while this coverage is in force;
  - (e) implant maintenance].]

**E. EXCLUSIONS**

**EXCLUSIONS ON  
PEDIATRIC DENTAL PLAN**

The following exclusions are not Covered Services. No payments will be made by Us for these services:

- (1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;
- (2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
- (3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
- (4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;
- (5) Services and supplies started and not completed before the patient was covered under this Plan, including but not limited to: an appliance, or modification of one, where an impression was made

- before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
- (6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
  - (7) Space maintainers;
  - (8) Sealants if re-sealed within a five (5) year period;
  - (9) Retreatment of a previous root canal or apicoectomy/periradicular surgery;
  - (10) Elective tooth extractions;
  - (11) Separate payments for open and drain palliative procedure when the root canal is completed on the same date of service;
  - (12) Expenses incurred for gingivectomy or gingivoplasty, periodontal scaling and root planning, full mouth debridement, and periodontal maintenance;
  - (13) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are defined as a Covered Dental Expense;
  - (14) Charges in excess of Usual, Reasonable and Customary charges amount stated in the "Schedule of Benefits" section of this Plan, or in excess of the Preferred Provider Fee Schedule;
  - (15) Charges for service provided for temporomandibular joint dysfunction (TMJ);
  - (16) Expenses incurred for congenital or developmental malformations, except as defined as a Covered Orthodontic Expense;
  - (17) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits, except as defined as a Covered Orthodontic Expense;
  - (18) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
  - (19) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, the patient's lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;
  - (20) Expenses for services for which the patient would not legally have to pay if there were no insurance, unless mandated by the State;
  - (21) Services not completed on or before the date of termination;
  - (22) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
  - (23) Expenses that are applied toward satisfaction of a Deductible, if any;
  - (24) Any service or procedure not commonly found within the scope of practice by a licensed dentist;
  - (25) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
  - (26) Chemotherapeutic agents and any other experimental procedures;
  - (27) Expenses incurred for veneers and related procedures;
  - (28) Services and supplies performed outside of the United States of America.

#### **EXCLUSIONS ON SUPPLEMENTAL DENTAL PLAN**

The following exclusions are not Covered Services. No payments will be made by Us for these services:

- (1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;

- (2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
- (3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
- (4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;
- (5) Services and supplies begun and not completed prior to the patient's effective date, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
- (6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
- (7) Pulp capping, if in conjunction with the installation of inlays, onlays or crowns and fillings or other lab fabricated restorations; including but not limited to inlays, onlays and crowns, preventative tests and examinations diagnostic casts and oral cancer screenings, and expenses incurred for sedative fillings, including charges for prescribed drugs, pre-medication or analgesia;
- (8) The initial installation of a prosthetic device (a fixed bridge, implant, or denture), including crowns and inlays which form abutments, to replace teeth missing before You were covered under the Policy, except when it also replaces a tooth that is extracted while covered unless such installation commences after You have remained continuously covered under this plan for at least three years immediately prior to the date such installation commences;
- (9) Implants, implant services and implant supported prosthetics[ are not covered for patients under the age of sixteen (16)];
- (10) Expenses incurred for veneers and related procedures;
- (11) Replacement of a lost or stolen or discarded prosthetic device;
- (12) Adjustment, repairs or relines of prostheses for a period of one (1) year from initial placement if the prostheses were paid for under this plan;
- (13) Expenses incurred for a core buildup will only be considered in conjunction with a crown;
- (14) If multiple endodontic treatments are necessary on the same tooth within a period of one (1) year, the allowance will be made for only one (1) procedure;
- (15) X-rays are considered an integral part of the endodontic procedure rather than a separate service and are therefore not eligible for benefits;
- (16) The extraction of immature erupting third molars and non-pathologic, asymptomatic third molar extractions;
- (17) Expenses for gross debridement allowed one time at the beginning of the periodontal treatment plan prior to pocket depth charting;
- (18) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
- (19) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are a Covered Dental Expense on this Plan;
- (20) Surgical procedures incidental to orthodontic treatment, including but not limited to, extraction of teeth solely for orthodontic reasons, exposure of impacted teeth, correction of micrognathia or macrognathia, or repair of cleft palate;
- (21) Charges for service provided for temporomandibular joint dysfunction (TMJ);
- (22) Expenses incurred for congenital or developmental malformations;
- (23) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
- (24) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits;
- (25) Chemotherapeutic agents and any other experimental procedures;



- (26) Charges in excess of Usual, Reasonable and Customary charges or in excess of the Calendar Year Maximum amount stated in the "Schedule of Dental Benefits" section of this Plan, or in excess of the Preferred Provider Fee Schedule;
- (27) Expenses that are applied toward satisfaction of a Deductible, if any;
- (28) Services and supplies performed outside of the United States of America;
- (29) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, Your lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;
- (30) Expenses for services for which You would not legally have to pay if there were no insurance;
- (31) Services not completed on or before the date of termination;
- (32) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
- (33) Any service or procedure not commonly found within the scope of practice by a licensed dentist. Such procedures are identified within the current Common Dental Terminology (CDT Codes) published by the American Dental Association;
- (34) Expenses incurred for services covered on a pediatric only dental plan.]

#### **F. RENEWABILITY**

This Policy may be renewed for additional periods of coverage by paying the premium when due or within the Grace Period until You reach age [19][65]. Each period of coverage runs from premium due date to premium due date.

#### **G. PREMIUMS**

We may change the amount of the required premium by giving You at least 60 days advance written notice. The Policy has a thirty-one (31) day Grace Period. That means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the Grace Period, the Policy will remain in force. If the required premium is not paid by the end of this Grace Period, the Policy will lapse as of the end of the Grace Period.

[Total Initial Premium due with Application: [\$XX.XX]]

**Underwritten by BEST Life and Health Insurance Company**

## VARIABILITY STATEMENT

IFD-PPO-CERT-0113TN

**Title Page** – The address of the company may change.

**Page 2** – The President and Secretary of the company may change. State of Jurisdiction will be North Carolina, is bracketed for filing in other states.

**Statement of Coverage** – Group and Insured information will be provided in the bracketed fields.

- **Subscriber Name** – Specific to individual purchasing the plan.
- **Certificate Effective Date** – Specific to the plan year for the Exchange.
- **Insured name(s) and Effective Dates(s)** – specific to client.
- **Plan information** – We are transitioning to a new administrative system. Our current administrative system provides plan selection information in the Statement of Coverage. The new administrative system will provide this information in the Schedule of Benefits. The Plan, Deductible, Annual Maximum, waiting period waiver is bracketed because these fields will no longer be provided once the new system is up and running.
- **Group Policy Number** – Specific to the client.

**Table of Contents** – page numbers may change. The subheadings under Benefits and Exclusions will show either the Pediatric Plan provisions only or all provisions

**Schedule of Benefits** –

- **Table of Benefits** - We are offering four “supplemental” plan designs and two pediatric dental plans. We have provided the full range of possibilities that would apply. In the final Certificate, only the plans that are selected will appear. A pediatric plan will always be shown.
- **Implants** – We may not offer this benefit on all plans.
- **The 80<sup>th</sup> percentile** – this is bracketed to allow either the 80<sup>th</sup> or 90<sup>th</sup> percentile to be offered.
- **Orthodontic benefits** – 24 month wait is bracketed on medically necessary to allow no waiting period.

**Part 2 Benefits and Exclusions** –

- **Covered Services** - We have bracketed Covered Services for the Supplemental Dental Plan. We may offer a 12-month wait on Major Services. A statement disclosing this information is provided before the Major Services header and is bracketed. Plans without a 12-month wait will not have this in their certificate.
- **24 Month Wait for Medically Necessary Orthodontic Benefits** – bracketed to allow for no waiting period.
- **Exclusions** - We have bracketed Exclusions for the Supplemental Dental Plan. Implants has been bracketed to match the benefit offering that would or would not be available on the plan.

**Effective Date for the Employee** - Item #3 is bracketed and will be specific to the Client. The Client may not want coverage effective on the date the employee qualifies.

**General Provisions**

- **Notice of Claim** – Address may change.

#### **Filing a Dental Claim**

- How to file a claim – URLs and contact information are bracketed to allow for changes, and possibly a third party administrator. Right now, there is no contract with a third party administrator, so BEST Life's current contact information is provided.
- Appealing the denial of a claim – address may change.

#### **IFD-PPO-OC-0113TN**

**Address** – Address may change.

#### **Schedule of Benefits –**

- **Table of Benefits** - We are offering four “supplemental” plan designs and two pediatric dental plans. We have provided the full range of possibilities that would apply. In the final Certificate, only the plans that are selected will appear. A pediatric plan will always be shown.
- **Implants** – We may not offer this benefit on all plans.
- **The 80<sup>th</sup> percentile** – this is bracketed to allow either the 80<sup>th</sup> or 90<sup>th</sup> percentile to be offered.
- **Orthodontic benefits** – 24 month wait is bracketed on medically necessary to allow no waiting period.

#### **Part 2 Benefits and Exclusions –**

- **Covered Services** - We have bracketed Covered Services for the Supplemental Dental Plan. We may offer a 12-month wait on Major Services. A statement disclosing this information is provided before the Major Services header and is bracketed. Plans without a 12-month wait will not have this in their certificate.
- **24 Month Wait for Medically Necessary Orthodontic Benefits** – bracketed to allow for no waiting period.
- **Exclusions** - We have bracketed Exclusions for the Supplemental Dental Plan. Implants has been bracketed to match the benefit offering that would or would not be available on the plan.

**Total Amount of Premium** – bracketed so that the Outline of Coverage may be provided along with a formal quote.

<b>State:</b>	Tennessee	<b>Filing Company:</b>	BEST Life and Health Insurance Company
<b>TOI/Sub-TOI:</b>	H10I Individual Health - Dental/H10I.000 Health - Dental		
<b>Product Name:</b>	Stand Alone Dental - Individual Market		
<b>Project Name/Number:</b>	Form Filing/Exchange Products		

## Rate Information

Rate data applies to filing.

<b>Filing Method:</b>	Prior Approval
<b>Rate Change Type:</b>	Neutral
<b>Overall Percentage of Last Rate Revision:</b>	0.000%
<b>Effective Date of Last Rate Revision:</b>	01/01/2014
<b>Filing Method of Last Filing:</b>	New Product

## Company Rate Information

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
BEST Life and Health Insurance Company	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

<b>State:</b>	Tennessee	<b>Filing Company:</b>	BEST Life and Health Insurance Company
<b>TOI/Sub-TOI:</b>	H10I Individual Health - Dental/H10I.000 Health - Dental		
<b>Product Name:</b>	Stand Alone Dental - Individual Market		
<b>Project Name/Number:</b>	Form Filing/Exchange Products		

## Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		ACTUARIAL MEMORANDUM	IFD-PPO-POL-0113TN	New		Actuarial Memorandum TN - Individual July 18 2013.pdf,
2		PEDIATRIC RATE CALCULATIONS	IFD-PPO-POL-0113TN	New		Individual Pediatric Rates - TN 06242013.pdf,
3		ADULT RATE CALCULATIONS	IFD-PPO-POL-0113TN	New		Individual Supplemental Rates - TN 06242013.pdf,

## Actuarial Memorandum

### Responses to your questions in the Objection Letter

- 1 The change of policy forms will not affect rates
- 2 We will comply with all the applicable rules and State regulations regarding rates and benefits as prescribed in PHSA §2701, 45 CFR § 156.150, 45 CFR § 156.135 and 45 CFR § 156.130.
- 3 Revised.
- 4 See attached "Summary of Normalized Paid to Children 0-19" worksheet.
- 5 A revised trend factor of 3% per year is used to project costs data developed above from July 1, 2011 (mid-point of the experience period from 2010 to 2012) to July 1, 2014 (mid-point of the premium period from January 1, 2014 to December 31, 2014). As reported by the Bureau of Labor Statistics, the average annual inflation rate in the United States is 3.35% from 1914 until now but is only 2.7% from 2011 to 2012. We believe low inflation rates in the recent years will not sustain and rates will likely get back to historical level soon. Therefore, an annual trend rate of 3% is used in our projections.
- 6
  - a Average charges by procedure code are developed using our California data from 2010 to 2012
  - b The following standard company assumptions are applied to the average charges:
    - o Network use of 0.358, In-Network discount of 0.625, Out-of-Network discount of 0.767, Deductible factors of 0.9 & 0.85, Annual Maximum Limit adjustments of 0.9 and 0.95.
  - c Actual coinsurance percentage will be applied and the total claim cost by procedure code is determined as the sum of the average In-Network cost and the average Out-of-Network cost.
  - d Weighted average base cost by class is developed using national frequency by procedure code from the 2010 HealthMaps Dental Rate Manual. Costs by class are further rolled up using standard company assumptions
  - e. The actuarial value of the plan will be determined by comparing total net costs before and after costs sharing adjustments.
- 7 The net costs shown was calculated using unrounded numbers not shown. Unrounded base cost of \$37.14 is \$37.143783, unrounded trend of 1.09 is 1.092727 and unrounded state factor of 0.65 is 0.646098.
- 8 See attached Determination of Age Factor. Standard company retention of 32.25% (administration – 13.50%, premium tax – 1.75%, user fees – 3.50%, commissions – 10.00% and profit – 3.50%) is used to arrive at the target loss ratio of 67.75%.
9. See 4 and 6 above

## Scope and Purpose

This is a new PPO product rate filing to satisfy the Stand-Alone Supplemental and Pediatric Dental Plans Rate Filing requirements for the Tennessee Health Benefit Plan under individual policy number IFD-PPO-POL-0113TN. The form filing does not replace previously approved forms.

## Description of Benefits

The policy provides benefits for two dental products: a Pediatric Dental Plan and an optional Supplemental Dental Plan. The Pediatric Dental plans offer the essential pediatric oral benefits required by the Affordable Care Act (ACA). Individuals will have the option of purchasing a high or low plan that meets the Actuarial Value required by the ACA. Individuals will also have the option of purchasing additional coverage for other family members, older than 19 and may choose from three Supplemental dental plans.

These plans are designed to be marketed to individuals through the Federal Exchange market. The individual will be the Policyholder for this filing.

Children to age 19 are eligible to enroll on the Pediatric Dental Plan. Adults and child dependents ages 19 to 26 are eligible to enroll on the Supplemental Dental Plan.

## Benefit Renewability

The policies are standard individual contracts. Coverage for individuals is renewable at the option of the policyholder. The Company reserves the right to increase premiums.

## Proposed Effective Date

January 1, 2014

## Description of Rate Calculations

- Base claim costs are developed using our company California claims experience from 2010 to 2012.
- Base claim costs are adjusted to reflect the plan design and adjusted for area using the 2010 HealthMaps Dental Rate Manual.
- A dental trend factor of approximately 3% per year, for 3 years, is used to project future expected claims and is included in the premium rate structure.
- Standard company retention of 32.25% (administration – 13.50%, premium tax – 1.75%, user fees – 3.50%, commissions – 10.00% and profit – 3.50%) is applied.
- Individual rates for the Supplemental Plans do not include premiums for the Pediatric Plans.

### Anticipated Future Loss Ratio

The anticipated future loss ratio for this policy is expected to be 67.75%. The loss ratio is computed as follows:

$$\text{Loss Ratio} = \frac{\text{Expected Incurred Claims}}{\text{Expected Earned Premium}}$$

Incurred claims are total claims for covered expenses paid on behalf of a covered person while coverage is in force, summed for all covered persons. Earned premium is the premium for each covered person for the period coverage is in force, summed for all covered persons.

### Certification

I, Adam S. Chan, Actuary for BEST Life and Health Insurance Company ("BEST"), NAIC #90638, domiciled in Texas, do hereby certify that to the best of my knowledge and judgment, this rate submission is in compliance with the applicable laws and regulations of Tennessee and all applicable Actuarial Standards of Practice, including ASOP No. 8, and that the attached rates are reasonable in relation to the benefits provided and are not excessive, inadequate, or unfairly discriminatory.



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Adam S. Chan, A.S.A., M.A.A.A.  
Corporate Actuary  
BEST Life and Health Insurance Company  
Irvine, California

July 18, 2013  
Date



## Tennessee Health Insurance Exchange Rate Filing

### Individual Dental - Essential Pediatric Plans

	High Plan - Actuarial Value 85%	Low Plan - Actuarial Value 70%
	Per Child*	Per Child*
Base Cost	\$ 37.14	\$ 28.25
Trend	1.09	1.09
State factor	0.65	0.65
Net Cost	\$ 26.22	\$ 19.95
Administrative	13.50%	13.50%
Premium Tax	1.75%	1.75%
User Fees**	3.50%	3.50%
Broker Commission	10.00%	10.00%
Profit	3.50%	3.50%
Target Loss Ratio	67.75%	67.75%
Final Rate**	\$ 38.71	\$ 29.44

\* Children to age 19 are eligible to enroll on the Pediatric Dental Plans.

\*\* User fees of 3.5% imposed by the Department of Health and Human Services are included.

\*\* Apply area factors from Summary of Area Factors to determine rates by different rating areas.

## Tennessee Health Insurance Exchange Rate Filing

### Individual Dental - Supplemental Plans

High Plan	Mid Plan	Basic Plan
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Base Cost	\$ 44.15	\$ 36.71	\$ 28.09
Trend	1.09	1.09	1.09
State factor	0.65	0.65	0.65
Net Cost	\$ 31.17	\$ 25.92	\$ 19.83

Administrative	13.50%	13.50%	13.50%
Premium Tax	1.75%	1.75%	1.75%
User Fees*	3.50%	3.50%	3.50%
Broker Commission	10.00%	10.00%	10.00%
Profit	3.50%	3.50%	3.50%

Target Loss Ratio	67.75%	67.75%	67.75%
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Rate	\$ 46.01	\$ 38.26	\$ 29.27
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#### Final Rate Per Individual\*\*\*

Age 19 to 26**	\$ 43.06	\$ 35.81	\$ 27.40
Age 26 to 65	\$ 46.01	\$ 38.26	\$ 29.27
Age 65 and Up	\$ 55.21	\$ 45.91	\$ 35.12

\* User fees of 3.5% imposed by the Department of Health and Human Services are included.

\*\* Adults and child dependents ages 19 to 26 are eligible to enroll on the Supplemental Dental Plans.

\*\*\* Apply area factors from Summary of Area Factors to determine rates by different rating areas.

<b>State:</b>	Tennessee	<b>Filing Company:</b>	BEST Life and Health Insurance Company
<b>TOI/Sub-TOI:</b>	H10I Individual Health - Dental/H10I.000 Health - Dental		
<b>Product Name:</b>	Stand Alone Dental - Individual Market		
<b>Project Name/Number:</b>	Form Filing/Exchange Products		

## Supporting Document Schedules

<b>Satisfied - Item:</b>	Cover Letter Accident & Health
<b>Comments:</b>	Please refer to the General Information Description Field.
<b>Attachment(s):</b>	
<b>Item Status:</b>	Approved
<b>Status Date:</b>	08/12/2013

<b>Satisfied - Item:</b>	Description of Variables
<b>Comments:</b>	Acknowledged and followed.
<b>Attachment(s):</b>	
<b>Item Status:</b>	Approved
<b>Status Date:</b>	08/12/2013

<b>Bypassed - Item:</b>	Filing Fees
<b>Bypass Reason:</b>	Using EFT.
<b>Attachment(s):</b>	
<b>Item Status:</b>	Approved
<b>Status Date:</b>	08/12/2013

<b>Satisfied - Item:</b>	Readability Certification
<b>Comments:</b>	
<b>Attachment(s):</b>	Readability Certification_Ex.pdf
<b>Item Status:</b>	Approved
<b>Status Date:</b>	08/12/2013

<b>Bypassed - Item:</b>	Third Party Authorization
<b>Bypass Reason:</b>	N/A
<b>Attachment(s):</b>	

<b>State:</b>	Tennessee	<b>Filing Company:</b>	BEST Life and Health Insurance Company
<b>TOI/Sub-TOI:</b>	H10I Individual Health - Dental/H10I.000 Health - Dental		
<b>Product Name:</b>	Stand Alone Dental - Individual Market		
<b>Project Name/Number:</b>	Form Filing/Exchange Products		

<b>Item Status:</b>	Approved
<b>Status Date:</b>	08/12/2013

<b>Bypassed - Item:</b>	Actuarial Memorandum A & H Certification - Individual
<b>Bypass Reason:</b>	Included in memorandum.
<b>Attachment(s):</b>	
<b>Item Status:</b>	Approved
<b>Status Date:</b>	08/12/2013

<b>Satisfied - Item:</b>	Accident & Health - Individual New Rates
<b>Comments:</b>	We have provided both under the Rate Tab.
<b>Attachment(s):</b>	
<b>Item Status:</b>	Approved
<b>Status Date:</b>	08/12/2013

<b>Satisfied - Item:</b>	Response to Objections to Rates
<b>Comments:</b>	
<b>Attachment(s):</b>	Determination of Age Factors.pdf Summary of Area Factors - TN 06242013.pdf Summary of Normalized Paid to Children 0-19.xlsx PM_FAQ10v2_508cr_052313.pdf Actuarial Memorandum TN - Individual July 18 2013.pdf
<b>Item Status:</b>	Approved
<b>Status Date:</b>	08/12/2013

<b>Satisfied - Item:</b>	redline
<b>Comments:</b>	
<b>Attachment(s):</b>	IFD-PPO-POL-0113TN(3)-redline.pdf
<b>Item Status:</b>	Approved

<b>SERFF Tracking #:</b>	BLHI-129004054	<b>State Tracking #:</b>	H-130559	<b>Company Tracking #:</b>	FORM FILING
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<b>State:</b>	Tennessee	<b>Filing Company:</b>	BEST Life and Health Insurance Company
<b>TOI/Sub-TOI:</b>	H10I Individual Health - Dental/H10I.000 Health - Dental		
<b>Product Name:</b>	Stand Alone Dental - Individual Market		
<b>Project Name/Number:</b>	Form Filing/Exchange Products		

<b>Status Date:</b>	08/12/2013
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<b>SERFF Tracking #:</b>	BLHI-129004054	<b>State Tracking #:</b>	H-130559	<b>Company Tracking #:</b>	FORM FILING
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<b>State:</b>	Tennessee			<b>Filing Company:</b>	BEST Life and Health Insurance Company
<b>TOI/Sub-TOI:</b>	H10I Individual Health - Dental/H10I.000 Health - Dental				
<b>Product Name:</b>	Stand Alone Dental - Individual Market				
<b>Project Name/Number:</b>	Form Filing/Exchange Products				

***Attachment Summary of Normalized Paid to Children 0-19.xlsx is not a PDF document and cannot be reproduced here.***

Readability Certification

Certification by an Officer of the Company

Persuant to TCA 56-7-1605(a)(1) and TCA 56-7-1605(e), I, Paul Peatross, am the President for the BEST Life and Health Insurance Company. I certify that the forms in this filing have been tested and meet the minimum required reading ease score.

Each form has a score of 43.5.



Signature of the Officer



Date

Tennessee Health Insurance Exchange Rate Filing

Determination of Age Factor for Age Band 19 to 26

Age factor from 2010 HealthMAPs Dental Manual (I-2)

under 30	2.80	2.80
30-34	2.87	
35-39	2.99	
40-44	3.00	
45-49	2.97	
50-54	3.00	
55-59	3.00	
60-64	3.10	
Average		2.99
Factor		93.6%

Determination of Age Factor for Age Band 65+

Age factor from Milliman Dental Guidelines

Average for 0-64	1.17
65+	1.40
Factor	20%



## Tennessee Health Insurance Exchange Rate

### Summary of Area Factors

#### Area Factor

Rating Area 1	0.99
Rating Area 2	1.04
Rating Area 3	1.01
Rating Area 4	1.03
Rating Area 5	0.93
Rating Area 6	1.02
Rating Area 7	0.97
Rating Area 8	0.99

# Qualified Health Plan (QHP) Webinar Series Frequently Asked Questions

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## Frequently Asked Questions (FAQs) # 10

Release Date: May 9, 2013

### Essential Health Benefits (EHBs)

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**Q1: We would like confirmation that the reasonable assurance provision in the EHB preamble applies to both individual and small group coverage.**

A1: Yes, issuers of both individual and small group plans off the Exchange must be reasonably assured that enrollees have obtained pediatric dental coverage through an Exchange-certified stand-alone dental plan.

**Q2: If a state discovers a clerical error or discovers an omission in the EHB template, how does the state change it? If the state wants to change a "decision" previously made about EHBs, how does the state change it?**

A2: Unfortunately, the benefits, limits, and explanations representing a summary of the benchmarks that is posted on CCIIO's website (<http://cciio.cms.gov/resources/data/ehb.html>) cannot be changed at this time. The add-in file that populates the Plans & Benefits template is derived from this information. Please use the "EHB Variance Reason" to identify benefits as "Additional EHB Benefit" that you feel are part of the benchmark.

**Q3: How much of the plan design of the benchmark transfers over to other carriers - just things listed as EHBs in the CCIIO template, things that could be categorized as EHBs by individual carriers, or all benefits (including those listed as "other" in the CCIIO template)?**

A3: Any benefits and services that the benchmark plan covers are considered EHB and other carriers must be sustainably equal to the benchmark. See 45 CFR 156.115(a)(1).

**Q4: Since carriers cannot substitute benefits across categories, categorization of benefits in the benchmark plan is important. What authority does the state have (or not have) to adjust categorization of benefits?**

A4: Enforcing states have the authority to categorize the benefits. In the preamble to the final rule on EHB, at 78 FR 12843 we noted that states maintain flexibility in defining benefits within the 10 statutory categories.

## QHP Webinar Series Frequently Asked Questions

Selected Responses

May 9, 2013

**Q5: Are pre-existing condition exclusions permitted on stand-alone pediatric dental plans?**

A5: Yes. Stand-alone dental plans are not subject to Public Health Service Act § 2704 - Prohibition of Preexisting Condition Exclusions or Other Discrimination Based on Health Status. Therefore, for the purposes of Exchange certification, CMS will not be publishing guidance on look-back periods; rather, applicable Federal and State laws apply.

**Q6: Are issuers allowed to include a 24-month waiting period for orthodontia services (currently part of the FEDVIP benchmark) for both stand-alone pediatric dental and an embedded medical product that includes the pediatric dental EHB?**

A6: Yes, this is permissible.

**Q7: How is preventive care defined in reference to the pediatric oral Essential Health Benefit (EHB) for the purpose of applying the requirement of no cost-sharing?**

A7: Pediatric oral benefits as an EHB category are defined by reference to each state's EHB-benchmark plan. A plan required to cover EHB is expected to offer benefits substantially equal to those pediatric oral benefits offered by the EHB-benchmark plan, as set forth in 45 CFR 156.115(a)(1). Preventive care must also be covered, with zero cost-sharing, but the specific preventive care services that are required to be covered are not tied to the state's EHB-benchmark, but instead to the certain preventive services as required by 45 CFR 147.130. For more information on preventive services that must be covered without cost sharing under the requirements of the Affordable Care Act, please see <http://www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html>.

**Q8: In preamble to the EHB final rule published February 25, 2013 page 12850 made note of a safe harbor that allows for the use of single-only plans' actuarial value (AV) for the family plan equivalents if family accumulators fell within a multiplier. When will CMS offer additional guidance on the safe harbor?**

A8: We do not intend to provide a multiplier at this time. Instead, in the 2014 Letter to Issuers on Federally-facilitated and State Partnership Exchanges, published on the CCIIO website on April 5, we provide guidance on options that issuers may use to calculating a plan's AV using the AV Calculator, where the deductibles and/or out of pocket maximum costs accumulate at the family level, depending on how the deductibles and/or out of pocket maximum costs accumulate. Please see the Letter to Issuers for further clarification at [http://cciio.cms.gov/resources/regulations/Files/2014\\_letter\\_to\\_issuers\\_04052013.pdf](http://cciio.cms.gov/resources/regulations/Files/2014_letter_to_issuers_04052013.pdf).

## QHP Webinar Series Frequently Asked Questions

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**Q9: Under the FEDVIP benchmark, there is a lifetime limit on orthodontia services (per child) in the amount of \$3,500. During a recent call it was (we believe) concluded that this limit could be included in a stand-alone pediatric dental plan because it's an excepted benefit plan. However, in reviewing the attestations we are required to sign, and the draft CMS letter to issuers posted on March 1, it looks like this limit may be prohibited. For example, the attestations require us to attest as follows:**

- Applicant attests that all stand-alone dental plans that it offers will comply with all benefit design standards and federal regulations and laws for stand-alone dental plans, as applicable, including that:
  - a. the out-of-pocket maximum for its stand-alone dental plan is reasonable for the coverage of pediatric dental EHB;
  - b. it offers the pediatric dental EHB;
  - c. it does not include annual and lifetime dollar limits on the pediatric dental EHB.
- Applicant attests that any stand-alone dental plans it offers are limited scope dental plans.
- Applicant attests that any stand-alone dental plans it offers will adhere to the standards set forth by HHS for the administration of advance payments of the premium tax credit.
- Applicant attests that it either offers no stand-alone dental plans or attests to all of the above.

**Can you offer any further guidance on this? Is it permissible to include in the \$3,500 lifetime max (per child) in our stand-alone pediatric dental plan?**

**A9:** Annual and lifetime limits cannot be applied to the pediatric dental EHB, as established in 45 CFR 155.1065. Thus, to the extent that orthodontia is considered part of the pediatric dental EHB (i.e., it is medically necessary), the benefit cannot have any annual and lifetime limits.

**Q10: For Exchange plans with an embedded dental benefit, is the dental carrier allowed to use different geographic area factors and/or network factors than the health plan geographic area and network factors?**

**A10:** No, this is not permissible.

## QHP Webinar Series Frequently Asked Questions

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**Q11: If the health plans are using the default 0-20 age band with a single age factor for children between 0-20, may the dental issuer apply separate age bands, such as 0-1, 2-10, 11-19 (children's dental only goes to age)?**

A11: For the purposes of completing the application for certification of stand-alone dental plans in the FFE, stand-alone dental plans must comply with the rating rules in order to fill out the rates table and the associated business rules table, which does not permit for age banding under age 20. Note that stand-alone dental plans, as excepted benefits, have additional flexibility to adjust premiums based on other rating factors. Please see the excerpt below and pages 31-32 of the Letter to Issuers released on April 5, 2013 at [http://cciio.cms.gov/resources/regulations/Files/2014\\_letter\\_to\\_issuers\\_04052013.pdf](http://cciio.cms.gov/resources/regulations/Files/2014_letter_to_issuers_04052013.pdf), for additional information.

Excerpt: "To the extent that stand-alone dental plans qualify as excepted benefits, they are not required to meet the rating rules of PHS Act section 2701(a) that underlie the QHP Rating Tables and business rules template. However, stand-alone dental plans will still need to complete these tables, and based on that information, CMS will display basic, comparable rate information for stand-alone dental plans on the web portal. When a consumer is directed to the stand-alone dental plan issuer to make the initial premium payment to effectuate enrollment, the stand-alone dental plan issuers would have the ability to make any premium adjustments beyond those accounted for in the Rating Tables and based on additional rating factors available to issuers of stand-alone dental plans."

**Q12: With respect to the maximum out-of-pocket (MOOP), we ask HHS to clarify that while EHB must accumulate to the MOOP, non-EHB may accumulate but are not required to. For instance, in order to design high deductible health plans (HDHPs) that are health savings account (HSA) certified, issuers would be able to accumulate all services (EHB and non-EHB) to the MOOP. In such a case, issuers would also include these non-EHB in the calculation of actuarial value (AV), which would be done outside of the AV Calculator.**

A12: No. For purposes of Calculating AV, non-EHB benefits may not accumulate towards MOOP amounts. Per section 1302(a) of the Affordable Care Act, the term "essential health benefits package" must consist of those benefits defined under section 1302(b), limits on cost-sharing for such coverage in accordance with section 1302(c), and a package that meets applicable metal levels. Section 1302(c) contains cost sharing requirements, including MOOP limitations. Furthermore, 1302(d) on AV clarifies that the level of coverage of a plan shall be determined on the basis that the EHB.

## QHP Webinar Series Frequently Asked Questions

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**Q13: In the preamble to the proposed rule on EHB at 77 FR 70654, HHS presents an example of a three-tiered network design and explains that the first two tiers would be considered in-network, and accumulate to the MOOP, while only the third tier would be out-of-network and not have to accumulate to the MOOP. We request, instead, that HHS permit issuers to consider the first tier as the primary in-network tier and accumulate only those costs to the OOP maximum as long as the first tier provides adequate access to providers, in compliance with network adequacy requirements. This would permit issuers to design a second tier that provides enhanced access to out-of-network providers relative to a third tier, with protections for members against significant costs from balance billing, without having to accumulate those costs to the MOOP. Requiring that these costs accumulate to the MOOP would make it unfeasible for issuers to offer members this benefit.**

A13: All benefits that are in-network have to count towards EHB, regardless of network adequacy requirements and no matter how broad or narrow the benefits are.

**Q14: We request clarification that issuers may have flexibility in applying the annual limitation on deductibles in the small group market or to use other types of cost sharing. For instance, issuers should be permitted to apply a deductible to only a subset of EHB, or to use fixed dollar co-pays for some services (e.g., physician office visits or prescription drugs) rather than making them subject to the deductible. Issuers could also choose not to have a deductible at all.**

A14: We interpret the limits in section 1302(c)(2) of the Affordable Care Act to apply to all EHB where there is a deductible being used as a form of cost sharing. However, the QHP has the option of excluding a particular category of benefits from the deductible, which, in effect, would be having a \$0 deductible for that category of benefit.

**Q15: We request clarification that while EHB must apply to the AV calculation and annual limitation on cost sharing, issuers may exclude additional state-required benefits that are outside the scope of the EHB from the AV calculation. Likewise, issuers would not be required to apply these additional state-required benefits to the annual limitation on cost sharing.**

A15: The AV Calculator was based on claims data from a standard population that included state mandated benefits. If the state required benefit is determined to be EHB, it should be applied to the annual cost sharing limits.

## **QHP Webinar Series Frequently Asked Questions**

Selected Responses

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**Q16: What further details can you provide on how states will reimburse issuers for benefit offer mandates (i.e., requirements to make a benefit optional through a rider) that are required to be offered in addition to the EHB?**

A16: We do not consider “offer only” or “make available” mandates to be required benefits that would be subject to state payment. Although the applicable state law requires issuers to offer the coverage/rider, the law does not mandate that the issuer actually provide the benefit to all enrollees in that market.

**Q17: Will states be required to defray the costs that qualified health plans (QHPs) sold outside the Marketplaces incur in meeting state benefits mandates (as they are required to do to have those mandates be required of QHPs sold through the Marketplace)?**

A17: Per section 1311(d)(3) of the Affordable Care Act, as implemented by 45 CFR 155.170, if the state requires a qualified health plan (QHP) to cover additional benefits beyond EHB, the state must defray the cost. The definition of QHP is established by section 1301(a) of the Affordable Care Act and implemented in 45 CFR 155.20. This definition requires that the QHP have in effect a certification issued or recognized by each Marketplace through which such plan is offered. The requirement to defray the cost of additional benefits applies to all QHPs, including QHPs offered outside of the Marketplace.

### **Federal Exchange**

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**Q18: Will issuer logos display on the FFE website?**

A18: No, logos will not be displayed on the FFE website.

**Q19: Do you know if/where during the FFE shopping experience shoppers will be presented with a phone number or URL to use if they have pre-enrollment questions regarding product offerings or how to enroll?**

A19: A consumer can access an issuer’s contact information via the link to the issuer’s plan brochure. We also intend to display the issuer’s contact information once a consumer has confirmed her/his plan selection.

## QHP Webinar Series Frequently Asked Questions

Selected Responses

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**Q20: Last I knew, the number of plans that an issuer could submit and presumably be approved and available on the FFE was not limited subject to the plans being materially differentiated in some way – can you verify (or correct) our understanding that for instance a gold plan and gold HSA qualified plan would be “different enough” for both to display as applicable in the shopping experience.**

**A20:** As detailed in the Letter to Issuers, we provide guidance on how the FFE will review for meaningful difference for 2014:

- “First, an issuer’s plans from a given state will be organized into subgroups based on plan type, metal level and overlapping counties/service areas.
- Second, CMS will review each subgroup to determine whether the potential QHPs in that subgroup differ from each other on least any one of the following criteria:
  - Different network;
  - Different formulary;
  - \$50 or more difference in both individual and family in-network deductibles;
  - \$100 or more difference in both individual and family in-network maximum-out-of-pocket; and
  - Difference in covered EHB.

If CMS flags a potential QHP for follow-up based on this review, we anticipate that the issuer will be given the opportunity to amend or withdraw its submission for one or more of the identified health plans. Alternatively, the issuer may submit supporting documentation to CMS explaining how the potential QHP is substantially different from others offered by the issuer for QHP certification and, thus, is in the interest of consumers to certify as a QHP. For example, an issuer may make the case that one QHP is an Accountable Care Organization. This additional information will factor into the determination of whether it is in the interest of the qualified individuals and qualified employers to certify the plan as a QHP (see 45 CFR 155.1000). CMS anticipates its approach related to meaningful difference may be updated in future years.”

### Exchange Forms

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**Q21: Is there any specific federal requirement for a company that may sell off Exchange health insurance (major med) products that it must file templates for any of the QHP certification process templates? If so, can you cite the section to help me with an explanation to the company?**

**A21:** Specific requirements for selling off the Exchange are of the purview of the state.



## QHP Webinar Series Frequently Asked Questions

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### Form Review

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**Q22: How are “optional” riders reflected in the CCIIO rate review template to differentiate what is an offer versus a rider that is embedded as required?**

A22: For Rate Review only, since EHBs cannot be optional, any “optional” rider must only cover benefits in addition to EHB, and we would expect any premium and claims for such benefits to appear in the “other” categories on worksheet 2.

Additionally, all benefits offered must be benefits for which the issuer is liable for paying the claims; setting the premium; and reporting on the annual statement, MLR, and other required reporting formats as part of the issuer’s claims and premium liabilities. Issuers are not allowed to report claims or premiums for “bundled” benefits, which are actually offered by another issuer but are sold in combination with or similar to a rider on their medical plan.

**Q23: What clarification can HHS provide for issuers that may make mid-year formulary changes to remove drugs that are found to be unsafe or ineffective or that become available over-the-counter? Specifically, we ask that issuers not be required to add a replacement drugs to the formulary mid-year to match the number of drugs covered by the EHB benchmark plan, as long as at least one drug in the class remains covered.**

A23: States will be responsible for monitoring drug lists for compliance with EHB policy as part of their review and enforcement responsibilities. Issuers will submit their drug lists to HIOS once (during the April submission period). As drug lists change, issuers are still responsible for meeting the EHB standard (the greater of one drug or the number of drugs in the state EHB benchmark plan in each USP category and class). State-based Exchanges could set their own rules in terms of requiring plans to notify the Exchange of any drug list changes or limit the frequency. Regardless, mid-year formulary changes should be infrequent. In addition to assuring formulary compliance with EHB, Exchanges should be aware of the potential for formulary discrimination.

## QHP Webinar Series Frequently Asked Questions

Selected Responses

May 9, 2013



### Essential Community Providers (ECPs)

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**Q24: Could an issuer enter into a contract with an Essential Community Provider (ECP), requiring members to have a referral to receive in-network benefits from the ECP? In this circumstance, the ECP would not appear in the provider directory.**

A24: Issuers may enter into contracts with ECPs and require members to get a referral to the ECP for non-primary care in-network benefits, to the extent that such referrals are part of the issuer's utilization management plan and program. Issuers may have such arrangements count towards the ECP inclusion standard. We are concerned, however, that the issuer might not list the ECP in the provider directory, and we discourage issuers from taking such steps that would prevent consumers from knowing whether they could access the contracted ECP. Issuers must ensure that such arrangements do not interfere with the requirement that provider networks have a sufficient number and geographic distribution of essential community providers that serve low-income and medically underserved individuals, as set forth at 45 CFR 156.235.

### Cost Sharing

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**Q25: If a carrier has separate in- versus out-of-network out-of-pocket maximum amounts but covers services such as emergency room and ambulance from any provider, including out-of-network providers, can the services from out-of-network ambulance companies or emergency rooms accrue to the in-network out-of-pocket maximum?**

A25: The general rule, as noted at 45 CFR 156.130(c), is that cost sharing for benefits provided out-of-network by a network plan do not count toward the annual limits on deductibles or maximum out-of-pocket limits. However, where the plan does not offer coverage of a particular service in network, the plan is not considered a network plan for purposes of this rule with respect to that service. Because plans are not permitted to limit coverage of emergency services set forth in 45 CFR 147.138(b) to network providers, plans are similarly not considered network plans for purposes of such services, and cost-sharing for such services received by non-network providers would apply to the out of pocket maximum.

**Q26: If an indemnity plan does not have a provider network, does that plan need to comply with annual limits on deductibles or maximum out-of-pocket limits?**

A26: Yes. A plan without a network must comply with the annual limits on deductibles or maximum out-of-pocket limits and cannot consider certain expenses to be non-network. The exception for non-network amounts only applies if a plan has a network (45 CFR 156.130(c)).

## QHP Webinar Series Frequently Asked Questions

Selected Responses

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### Stand-alone Dental Plans

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**Q27: What is the difference between an embedded pediatric dental benefit and a bundled pediatric dental benefit?**

A27: The pediatric dental benefit is considered embedded in a medical plan when it is offered like any other benefit under same premium and included in the same AV calculation for that medical plan. Although the medical plan issuer may contract with a dental issuer to offer the pediatric dental benefit the dental benefits provided under the contract would only be considered embedded if the medical plan issuer fully assumes all risks and liabilities of covering the dental benefit. A medical plan with an embedded dental benefit provided under contract would be considered a single plan for purposes of calculating the out-of-pocket maximum and actuarial value..

Under a bundled arrangement, a medical plan issuer would pair with a stand-alone dental plan to offer the pediatric dental benefit. The issuer of each of these plans would assume the risks and liabilities associated with providing coverage under its own plan. In this situation, the medical plan and the stand-alone dental plan would each be considered a separate plan, with the stand-alone dental plan considered an excepted benefit under title XXVII of the Public Health Service Act. Accordingly, each plan would be held to applicable standards, including those related to the out-of-pocket maximum and actuarial value.

### Rate Review

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**Q28: For rate review, how is a “new” product defined?**

A28: A “new” product is one which had no previous enrollment, does not represent a previous plan with enrollment which is being modified to comply with state or federal mandates or as defined by the appropriate state regulator.

## QHP Webinar Series Frequently Asked Questions

Selected Responses

May 9, 2013



### SHOP

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**Q29: When are the Small Business Health Options Programs (SHOPs) required to give employers the option to offer their employees more than one plan and perform premium aggregation?**

A29: A11: On March 11, 2013, we published a notice of proposed rulemaking at 78 FR 15553 that would implement a transitional policy for the 2014 plan year and give SHOPs the option of postponing the employee choice model until plan years beginning on or after January 1, 2015. The FF-SHOP would take this option and postpone employee choice until January 1, 2015. State-based SHOPs could, but need not, implement this option for 2014. To align with the transitional policy, this proposed rule also postpones the requirement to perform premium aggregation to plan years beginning on or after January 1, 2015, making it optional in coverage year 2014.

**Q30: What is the length of special enrollment periods in the SHOPs?**

A30: In a March 11, 2013 proposed rule (78 FR 15553), we proposed aligning the length of special enrollment periods in the SHOPs with those set forth under HIPAA. Special enrollment periods in group markets, as provided for in rules implementing HIPAA, last for 30 days after loss of eligibility for other private insurance coverage or after a person becomes a dependent through marriage, birth, adoption, or placement for adoption. The proposed rule also would clarify that, consistent with HIPAA, there would be a 60-day special enrollment period for any qualified employee or dependent of a qualified employee who has become ineligible for Medicaid or CHIP or who has become eligible for state premium assistance under a Medicaid or CHIP program.

**Q31: Will the geographic area premium rating factor in the small group market be based on the geographic area of the employee or that of the employer? Will this approach apply only for plans offered through the FF-SHOPs, or will it apply market-wide?**

A31: A13: We intend to propose in future rulemaking that the geographic area premium rating factor must be based on the employer's primary business location in each state. This would apply both inside and outside of the SHOP. In the context of the FF-SHOPs, we intend to propose that an employer, except multi-state employers, generally may have only one SHOP account per state. Multi-state employers will still be able to establish either one SHOP account for all employees or establish multiple SHOP accounts in each state with a business location. We intend to propose that, where a multi-state employer has established an account in more than one state, the primary business location of the business in each applicable state must be used for geographic rating area purposes.

## **QHP Webinar Series Frequently Asked Questions**

Selected Responses

May 9, 2013

### **Q32: Will employers be able to enroll in the FF-SHOPs via an issuer's website in 2014?**

A32: No. To ensure a smooth transition to employee choice beginning in 2015 when an employer will be able to offer multiple plan options from various issuers, enrollment through the FF-SHOP website will be the only enrollment channel available for 2014. Employee choice needs to be functional for employers renewing SHOP plan options for 2015 as of October 1, 2014, and testing needs to occur as early as early summer 2014. Thus, development of a single sign-on for employers in 2014 is the most expedient manner to transition to employee choice for 2015.

### **Q33: Will there be a call center supporting employers and agents/brokers working with SHOP?**

A33: Yes. There will be a call center available to support employers with enrollment related matters in 2014 and beginning in 2015 for payment related matters. Agents and brokers working with employers will also be able to access the SHOP call center.

### **Q34: Will quarterly rate increases be allowed in the SHOP?**

A34: Issuers participating in SHOP will be able to submit trend increases to their rates at the time of their original QHP application and, after that, whenever submitting new rates. We intend to propose an amendment to 45 CFR 155.705(b)(6) clarifying that, consistent with the general rules for the small group market, issuers in all SHOPs will be permitted to increase rates no more frequently than quarterly. We also intend to propose that issuers with plans offered through the FF-SHOPs will be able to submit non-trend rate updates on a quarterly basis beginning in July 2014. (As we have previously explained in guidance, it will not be possible for the FF-SHOPs to process non-trend rate changes until the third quarter of 2014.) Issuers will be notified when the FF-SHOPs begin processing non-trend quarterly rate updates. Regardless of when an employer enrolls in a plan through a SHOP, the rates applied to that employer's plan must be guaranteed for the 12 months of the plan year.

### **Q35: Will CMS be providing guidance related to the reconciliation process and/or the content of the monthly reconciliation file?**

A35: Yes. CMS intends to publish guidance this summer that, will contain a detailed description of the enrollment reconciliation process; the content and layout of the monthly file; business logic edits the FFM will use in processing the reconciliation file; record matching criteria; a final list of the data elements to be compared in the reconciliation process; the format and content of discrepancy reports, including sample reports; and instructions for transmitting discrepancy reports to issuers and SBMs. This guidance will be relevant for issuers in both the FFM and SBMs.

## QHP Webinar Series Frequently Asked Questions

Selected Responses

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### **Q36: Will CMS publish further updates to the 834 Enrollment Companion Guide?**

A36: Yes. CMS released the Companion Guide for FFM enrollment transactions in January 2013, and we published an update in March. The current version of the Companion Guide can be found at: <http://cciio.cms.gov/resources/regulations/Files/companion-guide-for-ffe-enrollment-transaction-v1.5.pdf>.

Updates typically will be made when a significant technical change has been identified or a business process is modified, resulting in a change to content in a Segment or Loop. Future updates may also be made if testing reveals the need for further clarification on any of the transactions contained in the Companion Guide.

## Benefits Template

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### **Q37: We have a question on an item on the Summary of Benefits and Coverage (SBC) template. Please explain what is meant by “Abortion for Which Public Funding is Prohibited.” Is that intended for states that have passed legislation prohibiting abortion coverage in QHPs sold through the Marketplace, or other legislation related to abortion?**

A37: As defined in the Marketplace regulation at 45 CFR 156.280(d)(1), “abortions for which public funding is prohibited” includes those abortion services for which the expenditure of Federal funds appropriated for CMS is not permitted. More information on this topic is available at: <http://www.whitehouse.gov/the-press-office/executive-order-patient-protection-and-affordable-care-acts-consistency-with-longst>.

## HSA Plan Variations

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### **Q38: How should QHP issuers indicate health savings account (HSA) eligibility if the standard plan is has-eligible, but one of the cost-sharing reduction plan variations is not HSA-eligible?**

A38: If a QHP issuer chooses to offer a high deductible health plan (HDHP) standard plan, with associated plan variations that are not eligible for pairing with an HSA, the QHP issuer should still select “yes” in the “HSA Eligible” field on the Plans & Benefits template.

## QHP Webinar Series Frequently Asked Questions

Selected Responses

May 9, 2013



### State Mandates

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**Q39: If a state enacts a new requirement that issuers that provide coverage of intravenous (IV) chemotherapy must cover oral chemotherapy at parity, does the state have to defray the cost?**

A39: No. We do not consider such payment parity bills to create a requirement to cover a new benefit. In addition, in the preamble to the final rule on EHB at 78 FR 12845, we stated that plans are permitted to go beyond the number of drugs offered by the benchmark without exceeding EHB.

**Q40: If a state enacts a new requirement for applied behavioral analysis (ABA) therapy, is that a benefit in excess of EHB, or can ABA be considered EHB because it is a service specific to an EHB category (falls within habilitative or mental health including behavioral health treatment)?**

A40: *Defining* habilitative services would not result in a mandate, but *requiring* specific treatments/benefits, including ABA, creates a new mandate. Below is an example of a definition of habilitative services and a mandate for services, for illustrative purposes.

Example of definition - Habilitative benefits for purposes of the state's EHB benchmark plan are defined as follows: "Habilitative services are services that help a person retain, learn, or improve skills and functioning for daily living that are offered in parity with, and in addition to, any rehabilitative services offered in the state's EHB benchmark plan. Parity in this context means of like type and substantially equivalent in scope, amount, and duration."

Example of mandate – A bill requires private insurance companies to provide coverage under group health insurance policies for psychiatric care; psychological care; habilitative or rehabilitative care (including ABA therapy); therapeutic; and pharmacy care to children who have been diagnosed with autism spectrum disorder (ASD).

## QHP Webinar Series Frequently Asked Questions

Selected Responses

May 9, 2013

**Q41: Our state has a mandated adoption indemnity benefit that states if an insured has coverage for maternity benefits on the date of an adoptive placement, the insured's policy shall provide an adoption indemnity benefit payable to the insured, if a child is placed for adoption with the insured within 90 days of the child's birth. This allows for a \$4000 payment. We can provide that payment to the insured or apply it towards plan benefits-for example the deductible. There is no requirement to provide any specific benefits. This mandate is not included in our benchmark plan as it is a state employee plan and not subject to this state mandate. Our question is whether this benefit is considered EHB? If so, does the benefit dollar limit have to be removed?**

**A41:** As stated in the preamble to the final rule on EHB at 78 FR 12838, we interpret “state-required benefits” to include the care, treatment and services that an issuer must provide to its enrollees. Other state laws that do not relate to specific benefits, including those relating to providers and benefit delivery method, are not considered state-required benefits. In this case, there is no requirement to cover a specific benefit. The issuer is required to pay a certain amount to the insured and the insured can use that money in any way. The requirement does not pertain to health services and would not fit into any of the 10 EHB categories. Therefore, it is not EHB and the prohibition on dollar limits and the requirement to defray the cost would not apply.

### Grace Periods

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**Q42: 45 CFR 156.270(d) provides for a grace period of three consecutive months for QHP enrollees who receive APTC. Section 156.270(d)(1) states that an issuer must pay all appropriate claims for services in the first month of the grace period and may pend claims for services in the second and third months of the grace period. Under HIPAA regulations regarding administrative simplification requirements for electronic transactions and code sets, 45 CFR Part 162, providers are required to use the National Council for Prescription Drug Programs (NCPDP) Telecommunications Standards, Version D, Release 0, when billing pharmacy claims. This standard does not contain a transaction allowing a claim to be pended. How should issuers handle pharmacy claims in months two and three of the grace period?**

**A42:** 45 CFR 156.270(d) does not require issuers to pay claims during months two and three of the grace period. Thus, issuers may pend these claims. However, issuers may not be able to pend pharmacy claims, only pay or deny such claims. In such instances, where it is not possible for the issuer to pend the claim, the issuer may deny the claim. If an enrollee pays for a drug out-of-pocket during the second or third months of the grace period due to an issuer's denial of the claim and subsequently pays his or her share of the premium so as to no longer be in the grace period, that enrollee may submit a receipt, and the issuer must reimburse its share of the cost directly to the enrollee. Thus, the enrollee can be made whole even if a claim cannot technically be pended.



## QHP Webinar Series Frequently Asked Questions

Selected Responses

May 9, 2013

**Q43: 45 CFR 156.270(d) provides for a grace period of three consecutive months for QHP enrollees who receive APTC. Section 156.270(d)(1) states that an issuer must pay all appropriate claims for services in the first month of the grace period and may pend claims for services in the second and third months of the grace period. If a QHP provides for the dispensing of a 90-day supply of drugs, does a QHP issuer have to provide the full 90-day supply if an enrollee is in the first month of the grace period?**

A43: Yes, the issuer should provide the full 90-day supply, pursuant to 45 CFR 156.270(d).

### Risk Corridor

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**Q44: Will offering the identical benefit plan under two separate HIOS Product IDs on and off the Exchange preclude participation in the risk corridor program?**

A44: Section 1342 of the Affordable Care Act directs HHS to establish a temporary risk corridors program during the years 2014 through 2016 and requires that all Issuers of qualified health plans in the individual and small group markets to participate. We are currently working on the risk corridors program. The approach of establishing separate product IDs for QHPs on and off the Exchange would not preclude the QHPs off the Exchange from participating in the risk corridors program. As we continue our work, we will consult with stakeholders to ensure that we provide sufficient flexibility.

## Actuarial Memorandum

### Responses to your questions in the Objection Letter

- 1 The change of policy forms will not affect rates
- 2 We will comply with all the applicable rules and State regulations regarding rates and benefits as prescribed in PHSA §2701, 45 CFR § 156.150, 45 CFR § 156.135 and 45 CFR § 156.130.
- 3 Revised.
- 4 See attached "Summary of Normalized Paid to Children 0-19" worksheet.
- 5 A revised trend factor of 3% per year is used to project costs data developed above from July 1, 2011 (mid-point of the experience period from 2010 to 2012) to July 1, 2014 (mid-point of the premium period from January 1, 2014 to December 31, 2014). As reported by the Bureau of Labor Statistics, the average annual inflation rate in the United States is 3.35% from 1914 until now but is only 2.7% from 2011 to 2012. We believe low inflation rates in the recent years will not sustain and rates will likely get back to historical level soon. Therefore, an annual trend rate of 3% is used in our projections.
- 6
  - a Average charges by procedure code are developed using our California data from 2010 to 2012
  - b The following standard company assumptions are applied to the average charges:
    - o Network use of 0.358, In-Network discount of 0.625, Out-of-Network discount of 0.767, Deductible factors of 0.9 & 0.85, Annual Maximum Limit adjustments of 0.9 and 0.95.
  - c Actual coinsurance percentage will be applied and the total claim cost by procedure code is determined as the sum of the average In-Network cost and the average Out-of-Network cost.
  - d Weighted average base cost by class is developed using national frequency by procedure code from the 2010 HealthMaps Dental Rate Manual. Costs by class are further rolled up using standard company assumptions
  - e. The actuarial value of the plan will be determined by comparing total net costs before and after costs sharing adjustments.
- 7 The net costs shown was calculated using unrounded numbers not shown. Unrounded base cost of \$37.14 is \$37.143783, unrounded trend of 1.09 is 1.092727 and unrounded state factor of 0.65 is 0.646098.
- 8 See attached Determination of Age Factor. Standard company retention of 32.25% (administration – 13.50%, premium tax – 1.75%, user fees – 3.50%, commissions – 10.00% and profit – 3.50%) is used to arrive at the target loss ratio of 67.75%.
9. See 4 and 6 above

## Scope and Purpose

This is a new PPO product rate filing to satisfy the Stand-Alone Supplemental and Pediatric Dental Plans Rate Filing requirements for the Tennessee Health Benefit Plan under individual policy number IFD-PPO-POL-0113TN. The form filing does not replace previously approved forms.

## Description of Benefits

The policy provides benefits for two dental products: a Pediatric Dental Plan and an optional Supplemental Dental Plan. The Pediatric Dental plans offer the essential pediatric oral benefits required by the Affordable Care Act (ACA). Individuals will have the option of purchasing a high or low plan that meets the Actuarial Value required by the ACA. Individuals will also have the option of purchasing additional coverage for other family members, older than 19 and may choose from three Supplemental dental plans.

These plans are designed to be marketed to individuals through the Federal Exchange market. The individual will be the Policyholder for this filing.

Children to age 19 are eligible to enroll on the Pediatric Dental Plan. Adults and child dependents ages 19 to 26 are eligible to enroll on the Supplemental Dental Plan.

## Benefit Renewability

The policies are standard individual contracts. Coverage for individuals is renewable at the option of the policyholder. The Company reserves the right to increase premiums.

## Proposed Effective Date

January 1, 2014

## Description of Rate Calculations

- Base claim costs are developed using our company California claims experience from 2010 to 2012.
- Base claim costs are adjusted to reflect the plan design and adjusted for area using the 2010 HealthMaps Dental Rate Manual.
- A dental trend factor of approximately 3% per year, for 3 years, is used to project future expected claims and is included in the premium rate structure.
- Standard company retention of 32.25% (administration – 13.50%, premium tax – 1.75%, user fees – 3.50%, commissions – 10.00% and profit – 3.50%) is applied.
- Individual rates for the Supplemental Plans do not include premiums for the Pediatric Plans.

### Anticipated Future Loss Ratio

The anticipated future loss ratio for this policy is expected to be 67.75%. The loss ratio is computed as follows:

$$\text{Loss Ratio} = \frac{\text{Expected Incurred Claims}}{\text{Expected Earned Premium}}$$

Incurred claims are total claims for covered expenses paid on behalf of a covered person while coverage is in force, summed for all covered persons. Earned premium is the premium for each covered person for the period coverage is in force, summed for all covered persons.

### Certification

I, Adam S. Chan, Actuary for BEST Life and Health Insurance Company ("BEST"), NAIC #90638, domiciled in Texas, do hereby certify that to the best of my knowledge and judgment, this rate submission is in compliance with the applicable laws and regulations of Tennessee and all applicable Actuarial Standards of Practice, including ASOP No. 8, and that the attached rates are reasonable in relation to the benefits provided and are not excessive, inadequate, or unfairly discriminatory.



---

Adam S. Chan, A.S.A., M.A.A.A.  
Corporate Actuary  
BEST Life and Health Insurance Company  
Irvine, California

July 18, 2013  
Date

# ~~Individual Insurance Policy~~

## ~~Dental PPO Plan~~



~~[2505 McCabe Way  
Irvine, California 92614]  
State of Domicile: Texas~~

~~Notice to Buyer: This Policy provides dental  
coverage [for children] only.~~

---

**BEST Life and Health Insurance Company**  
[2505 McCabe Way  
Irvine, California 92614]

A STOCK COMPANY  
(Herein called the Company)

**BEST Life and Health Insurance Company ("BEST Life")** is issuing this Policy in consideration of the accuracy of representations made in Your application and Your payment of premiums for Policy coverage.

**READ YOUR POLICY CAREFULLY:** This Policy is a legal contract between You (owner of this Policy) and Us.

**GOVERNING JURISDICTION:** The Policy is issued in the State of Utah. It shall be construed in accordance with the laws of the issuing State.

**NOTICE OF TEN DAY RIGHT TO EXAMINE:** We want You to fully understand and be satisfied with the insurance coverage. If for any reason You are not satisfied, You may return this Policy to Your agent or to Our home office within ten (10) days of receipt and Your premium will be fully refunded. Coverage will then be void retroactive to the Insurance Effective Date.

**RENEWAL AND PREMIUM PAYMENT PROVISIONS:** You may renew this Policy for additional coverage periods by paying the premium when due or within the Grace Period until the Insureds reach age [19][65]. Each period of coverage runs from premium due date to premium due date. We reserve the right to change premiums. Any such change will be made according to the table of premium rates that will apply to all policies with the same form and class in Your State. All future renewal premiums will be based on Your original issue age. We will notify You of any premium rate increase at least forty-five (45) days in advance. We cannot cancel this Policy while it is in force.

**IN WITNESS WHEREOF,** We have caused this Policy to be signed by Our President and Our Secretary. This Policy takes effect at 12:01 a.m. at Your residence on its Effective Date. This Policy terminates at 12:01 a.m. on the date any renewal premium is due and not paid, subject to the Grace Period.

[



**President**

]]



**Secretary**

**PPO DENTAL INSURANCE POLICY**

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**This Policy Is Not Valid  
Unless There Is a Complete Statement of Coverage**

**Statement of Coverage**

**DENTAL**

INSURANCE ~~SUBSCRIBER-POLICYHOLDER~~ NAME: [JOHN D. DOE]  
POLICY EFFECTIVE DATE: [01/01/2014]

**INSURED NAME(S) AND EFFECTIVE DATE(S):**

[JANE DOE 01/01/2014]

[JON DOE 01/01/2014]

[SUPPLEMENTAL PLAN: [PPO HIGH]

DEDUCTIBLE: [\$50]

ANNUAL MAXIMUM: [\$1,000]

PEDIATRIC DENTAL PLAN: [PPO HIGH]

DEDUCTIBLE: [\$50]

OUT OF POCKET MAXIMUM: [\$700 - ~~\$1400~~]

POLICY NO.: [XXXXXXXXXX]



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## PART 1 - SCHEDULE OF BENEFITS

This Policy is made valid on the effective dates shown for the listed Insureds on the Statement of Coverage.

Covered Services received by Insured from a Network Provider are reimbursed at the Network Provider's contracted Fee Schedule. Covered Services received by Insured from an Out-of-Network Provider are reimbursed at the [80<sup>th</sup>][90<sup>th</sup>] percentile of a Usual, Reasonable and Customary schedule. All Covered Services are subject to Cost Sharing as shown on the Schedule of Benefits.

### [Pediatric Dental Plan Schedule of Benefits For Children to Age 19]

Procedure Categories	[High][Low] Dental Plan	
	In-Network [Network Name]	Out-of-Network
<b>Out-of-Pocket Maximum</b>	\$700 for 1 Child \$1,400 for 2 or more Children	\$700 for 1 Child \$1,400 for 2 or more Children
<b>Annual Deductible</b> – Applies to Preventive services received In-Network or Out-of-Network	\$(35)[75]	\$(35)[75]
<del>Diagnostic &amp; Preventive</del> <b>Basic Services Coinsurance</b> [– Exams, cleanings, sealants, fluoride treatment x-rays]	100%	100%
<b>Medically Necessary Orthodontic Services Coinsurance</b> <del>(Medically-necessary Orthodontic Services only)</del>	50% [24 Month Wait]	30% [24 Month Wait]

**~~{Supplemental Dental Plan Schedule of Benefits  
For Adults and Dependent Children between 19 and 26}~~**

<del>{BESTOne Dental} [Advantage][Plus][Basic] Plan</del>	
<del>Benefits Description</del>	<del>In-Network [Network]      Out-of-Network</del>
<del>Annual Maximum-</del>	<del>[\$500—3,500]</del>
<del>Annual Deductible-</del> <del>(Applies to Basic and Major) —3 Deductible-</del> <del>Maximum per Family</del>	<del>[\$0-100]</del>
<del>Preventive Care Services</del> <del>Routine oral exam, cleanings, X-rays</del>	<del>[100-70]%      [100-70]%</del>
<del>Basic Services-</del> <del>Fillings (amalgam, porcelain &amp; plastic), anterior &amp;</del> <del>posterior composites, anesthesia (general or</del> <del>intravenous sedation), emergency palliative</del> <del>treatment, pathology</del>	<del>[90-50]%      [80-20]%</del>
<del>Major Services-</del> <del>Crowns &amp; gold fillings, inlays, onlays &amp; pontics,</del> <del>[implants,] fixed bridges, complete &amp; partial</del> <del>dentures</del>	<del>[60-0]%      [50-0]%</del>
<del>[Major Services Waiting Period]</del>	<del>12 Months]</del>
<del>Endodontic Services</del>	<del>[Basic][Major]</del>
<del>Periodontic Services</del>	<del>[Basic][Major]</del>
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<del>Usual and Customary Reimbursement</del>	<del>Fee Schedule      [80<sup>th</sup>][90<sup>th</sup>] Percentile</del>

}

## PART 2 - BENEFITS AND EXCLUSIONS

### COVERED SERVICES ON PEDIATRIC DENTAL PLAN

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Policy.

#### Preventive and Diagnostic Procedures Include:

- (1) Prophylaxis not more often than twice every twelve (12) months;
- (2) Topical application of fluoride (excluding prophylaxis) not more often than twice every twelve (12) months;
- (3) Topical fluoride varnish not more often than twice every twelve (12) months;
- (4) Sealants on permanent molars not more often than once every five (5) years;
- (5) Periodic oral evaluation not more often than twice every twelve (12) months;
- (6) Limited oral evaluation (problem focused) not more often than twice every twelve (12) months;
- (7) Comprehensive oral evaluation not more often than twice every twelve (12) months;
- (8) Comprehensive periodontal evaluation not more often than twice every twelve (12) months;
- (9) Intraoral complete X-rays or panoramic film not more often than once in a 360-month period;
- (10) Bitewing X-rays not more often than twice every twelve (12) months;
- (11) Vertical bitewings limited to eight (8) films.

~~[Note: Unless the twenty four (24) month waiting period requirement for Medically Necessary Orthodontic services has been met, the services below are not covered benefits for any treatment that began during the twenty four (24) month period immediately following Your effective date of coverage.]~~

**Medically Necessary Orthodontic Procedures Include:** [Note: Unless the twenty-four (24) month waiting period requirement for Medically Necessary Orthodontic services has been met, the services below are not covered benefits for any treatment that began during the twenty-four (24) month period immediately following the Insureds effective date of coverage.]

- 1.(1) For orthodontia services associated with the repair of cleft palate and palate or other severe craniofacial defects or injury for which the function of speech, swallowing or chewing is restored;
- 2.(2) Requires predetermination; and
- 3.(3) Coverage includes diagnosis, treatment plan, anticipated treatment time and cost estimate.

#### **EXCLUSIONS ON PEDIATRIC DENTAL PLAN**

The following exclusions are not Covered Services. No payments will be made by Us for these services:

- (1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;
- (2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
- (3) Expenses incurred as a result of voluntarily participating in a riot or insurrection or the commission of a felony;
- (4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;
- (5) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are defined as a Covered Dental Expense;
- (6) Expenses incurred for congenital or developmental malformations, except as defined as a Covered Orthodontic Expense;
- (7) Charges in excess of Usual, Reasonable and Customary charges amount stated in the "Schedule of Benefits" section of this Plan, or in excess of the Preferred Provider Fee Schedule;
- (8) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
- (9) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, the patient's lawful spouse, domestic partner, - child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;
- (10) Expenses for services for which the patient would not legally have to pay if there were no insurance, unless mandated by the State;
- (11) Services not completed on or before the date of termination;
- (12) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
- (13) Expenses that are applied toward satisfaction of a Deductible, if any;
- (14) Any service or procedure not commonly found within the scope of practice by a licensed dentist;
- (15) Expenses for services or supplies not defined as a Covered Dental Expense;
- (16) Services and supplies performed outside of the United States of America.

#### **~~{COVERED SERVICES ON SUPPLEMENTAL DENTAL PLAN~~**

~~Covered Services are those services described below, unless they are limited or excluded elsewhere in this Policy.~~

**~~CLASS I—Preventive Dental Procedures include:~~**

- ~~(1) Routine oral examination and diagnosis not more often than twice every twelve (12) months per individual;~~
- ~~(2) Bitewing x rays not more often than once every twelve (12) months per individual;~~
- ~~(3) Full mouth x rays or panoramic films are limited to once every five (5) years; any combination of eight (8) or more x rays (including but not limited to bitewings or periapicals/intraorals) will be combined into a full mouth x ray series;~~
- ~~(4) Prophylaxis not more often than once every six (6) months per individual.~~

**~~CLASS II—Basic Dental Procedures include:~~**

- ~~(1) Pathology;~~
- ~~(2) All fillings other than lab fabricated restorations (composite fillings limited to permanent anterior and posterior teeth);~~
- ~~(3) Emergency palliative treatment;~~
- ~~(4) Limited oral exam not more than once every six months;~~
- ~~(5) Simple extraction, excluding orthodontic extractions unless a orthodontic benefits are a Covered Dental Expense on this Plan;~~
- ~~(6) Surgical extraction, including impaction:
  - ~~• erupted tooth;~~
  - ~~• soft tissue impaction;~~
  - ~~• partial bony impaction;~~
  - ~~• complete bony impaction;~~~~
- ~~(7) General anesthesia or intravenous sedation when required for complex oral surgical procedures (partial and complete bony impacted extractions only);~~
- ~~(8) Periodontics (tissues and gums);~~
- ~~(9) Periodontal exam (not in addition to a routine oral exam);~~
- ~~(10) Periodontal maintenance (limited to once every six (6) months per individual following active periodontal treatment) and not on the same visit as a routine prophylaxis;~~
- ~~(11) Periodontal scaling and root planing (limited to once every 36 months and to two (2) quadrants per visit, and not in addition to a routine prophylaxis);~~
- ~~(12) Endodontics (pulp capping and root canal); and~~
- ~~(13) Oral surgery:
  - ~~(1) root recovery (surgical removal of residual root);~~
  - ~~(2) oral antral fistula closure;~~
  - ~~(3) removal of a dentigerous or odontogenic cyst;~~
  - ~~(4) incision and drainage of an abscess;~~
  - ~~(5) removal of lateral exostosis;~~
  - ~~(6) frenulectomy.~~~~

~~[Note: Unless the twelve (12) month waiting period requirement for Major Dentistry services has been met, the services below are not covered benefits for any treatment that began during the twelve (12) month period immediately following Your effective date of coverage.]~~

**~~CLASS III—Major Dental Procedures include:~~**

- ~~• Inlays, onlays, crowns and other lab fabricated restorations (not including veneers);~~
- ~~• Porcelain, porcelain fused to metal, or full gold crowns on permanent teeth;~~

- ~~Full or partial dentures or fixed bridgework or adding teeth to an existing denture, if required because of loss of functional natural teeth while the person is covered for this Benefit. The work must be done within twelve (12) months after the extraction and while this coverage is in force;~~
- ~~Replacement or alteration of full or partial dentures or fixed bridgework caused by the following while coverage is in force:
 
  - ~~(a) accidental injury requiring oral surgical treatment, or~~
  - ~~(b) oral surgical treatment involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus or redundant tissue, provided the replacement or alteration is done within twelve (12) months of the injury or surgical treatment.~~~~
- ~~Replacement of a full denture or bridgework if the replacement is made more than seven (7) years after the date of installation, unless:
 
  - ~~a. such replacement is made necessary by the initial extraction of an adjoining functional natural tooth; or~~
  - ~~b. the prosthesis, while in the oral cavity, has been damaged beyond repair as a result of a non-chewing injury while covered;~~~~
- ~~Repair or reline of dentures and bridgework;~~
- ~~Implants, as an alternative to a fixed prosthetic, (limited to once in a lifetime per site). The cost of the fixed prosthetic will be applied to the total value of the implant and implant related procedures, not to exceed the cost of the fixed prosthetic:
 
  - ~~the surgical placement of endosteal implant body including healing cap, where the bone and soft tissues are sound and healthy;~~
  - ~~implant supported prosthetics;~~
  - ~~eposteal and transosteal implants will be covered at the cost of the endosteal implant (if performed, member is responsible for additional fees);~~
  - ~~bone grafting and tooth extractions, provided the work is done while this coverage is in force;~~
  - ~~implant maintenance];~~~~

### **EXCLUSIONS ON SUPPLEMENTAL DENTAL PLAN**

The following exclusions are not Covered Services. No payments will be made by Us for these services:

- 
- (1) ~~Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;~~
- (2) ~~Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;~~
- (3) ~~Expenses incurred as a result of voluntarily participating in a riot or insurrection or the commission of a felony;~~
- (4) ~~Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;~~
- (5) ~~Services and supplies begun and not completed prior to the patient's effective date, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;~~
- (6) ~~Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;~~
- (7) ~~Pulp capping, if in conjunction with the installation of inlays, onlays or crowns and fillings or other lab fabricated restorations; including but not limited to inlays, onlays and crowns,~~

- ~~preventative tests and examinations diagnostic casts and oral cancer screenings, and expenses incurred for sedative fillings, including charges for prescribed drugs, pre medication or analgesia;~~
- ~~(8) The initial installation of a prosthetic device (a fixed bridge, implant, or denture), including crowns and inlays which form abutments, to replace teeth missing before You were covered under the Policy, except when it also replaces a tooth that is extracted while covered unless such installation commences after You have remained continuously covered under this plan for at least three years immediately prior to the date such installation commences;~~
  - ~~(9) Implants, implant services and implant supported prosthetics[ are not covered for patients under the age of sixteen (16)];~~
  - ~~(10) Expenses incurred for veneers and related procedures;~~
  - ~~(11) Replacement of a lost or stolen or discarded prosthetic device;~~
  - ~~(12) Adjustment, repairs or relines of prostheses for a period of one (1) year from initial placement if the prostheses were paid for under this plan;~~
  - ~~(13) Expenses incurred for a core buildup will only be considered in conjunction with a crown;~~
  - ~~(14) If multiple endodontic treatments are necessary on the same tooth within a period of one (1) year, the allowance will be made for only one (1) procedure;~~
  - ~~(15) X rays are considered an integral part of the endodontic procedure rather than a separate service and are therefore not eligible for benefits;~~
  - ~~(16) The extraction of immature erupting third molars and non-pathologic, asymptomatic third molar extractions;~~
  - ~~(17) Expenses for gross debridement allowed one time at the beginning of the periodontal treatment plan prior to pocket depth charting;~~
  - ~~(18) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;~~
  - ~~(19) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are a Covered Dental Expense on this Plan;~~
  - ~~(20) Surgical procedures incidental to orthodontic treatment, including but not limited to, extraction of teeth solely for orthodontic reasons, exposure of impacted teeth, correction of micrognathia or macrognathia, or repair of cleft palate;~~
  - ~~(21) Charges for service provided for temporomandibular joint dysfunction (TMJ);~~
  - ~~(22) Expenses incurred for congenital or developmental malformations;~~
  - ~~(23) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);~~
  - ~~(24) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits;~~
  - ~~(25) Chemotherapeutic agents and any other experimental procedures;~~
  - ~~(26) Charges in excess of Usual, Reasonable and Customary charges or in excess of the Calendar Year Maximum amount stated in the "Schedule of Dental Benefits" section of this Plan, or in excess of the Preferred Provider Fee Schedule;~~
  - ~~(27) Expenses that are applied toward satisfaction of a Deductible, if any;~~
  - ~~(28) Services and supplies performed outside of the United States of America;~~
  - ~~(29) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, Your lawful spouse, domestic partner, child, child of Your domestic partner, parent, step parent, grandparent, brother, sister, cousin or in-law;~~
  - ~~(30) Expenses for services for which You would not legally have to pay if there were no insurance;~~
  - ~~(31) Services not completed on or before the date of termination;~~
  - ~~(32) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;~~
  - ~~(33) Any service or procedure not commonly found within the scope of practice by a licensed dentist.~~

~~Such procedures are identified within the current Common Dental Terminology (CDT Codes) published by the American Dental Association;~~  
~~(34) Expenses incurred for services covered on a pediatric-only dental plan.]~~

### **PART 3 - LIMITATIONS AND COST SHARING**

#### **ACCESS TO CARE**

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##### **Using a Network Provider:**

BEST Life offers Insureds the option to save on out-of-pocket costs when care is provided by a Network Provider. A listing of General Dentists and Specialists is available. To find a Network Provider, please refer to the Network information provided on the ID Card.

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##### **How to Select a Dentist:**

Insureds on this Plan may obtain dental services from any licensed dental professional in the United States. To use the Plan, Insureds may directly contact the dentist of their choice and make an appointment. Insureds are advised to bring their ID Card to their appointment. The dentist may require a copy of the Insured's ID Card to confirm eligibility on this Plan.

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##### **How to Obtain a Referral:**

A dentist may determine that an Insured requires treatment from a dental provider that specializes in a type of dentistry (Specialist). The Insured does not need to contact BEST Life for a referral. The Insured can directly contact the Specialist to make an appointment. The Specialist may require information from the Insured's dentist to determine a treatment plan and may contact the dentist directly.

#### **ADVANCE NOTICE OF DENTAL TREATMENT**

~~Subscriber-Policyholder~~ or Insured should submit Advance Notice of Dental Treatment before treatment commences in order to obtain Predetermination of Covered Services, including services that are medically necessary. If dental services are performed without such Predetermination, We reserve the right to deny any claim submitted with respect to such Covered Services; provided however, that predetermination is not required for:

- (1) Covered Services for which the related expense is less than \$500 during any course of treatment ("course of treatment" means one treatment or one of a planned series of treatments resulting from dental examination);
- (2) Emergency treatment; or
- (3) Oral examination and prophylaxis.

Predetermination is required for the following dental services for children:

- (1) Orthodontia, including preorthodontic treatment visit.

Predetermination is required for the following dental services for adults and children 19 or older:

- (1) Crowns, Anterior, except with posts or root canal;
- (2) Crowns, 2 or more Posterior, except with posts or root canal;
- (3) Inlays or Onlays, 2 or more, except with posts or root canal;
- (4) Laminates;
- (5) Anterior composites;
- (6) 2 or more multiple surfaces;
- (7) Bridges – initial or replacement;



- (8) Eligible partial dentures – initial or replacement;
- (9) Periodontal surgery over \$500;
- (10) Full bony impactions, 2 or more.

We will have fifteen (15) days to furnish the provider with an Explanation of Benefits demonstrating whether the proposed treatment will be a Covered Service under this Policy.

## DEDUCTIBLES

**Annual Deductible:** The Annual Deductible shown in the Schedule of Dental Benefits will apply separately to each Insured. Each Insured must accumulate eligible expenses equal to the deductible amount.

## ALTERNATIVE PROCEDURES

If more than one treatment plan exists for a dental procedure, covered dental expenses will be based on the least expensive procedure that will produce a result that meets professionally recognized standards. If the Insured's provider elects the more expensive treatment, the ~~Insured or Subscriber Policyholder~~ shall be responsible for any charges that are greater than the covered expense for the less expensive treatment.

## PART 4 - DEFINITIONS

**Annual:** The twelve (12) month period beginning on the effective date of the Policy and ending on the termination date of the Policy. The Annual time frame will be applied to the Deductible and the Annual Maximum amount.

**Annual Deductible:** The amount each Insured must satisfy before Benefits are payable by Us. To satisfy the Annual Deductible, the Insured must accumulate expenses for Covered Services equal to the Deductible amount shown on the Schedule of Benefits.

**[Annual Maximum:** The maximum amount BEST Life will reimburse for covered services during a twelve (12) month period for each Insured person. Once the full Annual Maximum amount has been paid, no additional services will be reimbursed for the remainder of that year.]

**Child:** A dependent child who meets the definition of Eligible Person may be enrolled and covered under this Policy, as follows:

1. A child who is less than nineteen (19) years of age on the coverage effective date will be covered on the Pediatric Dental Plan until the first of the month after that child becomes nineteen (19) years of age;
2. A child who is older than nineteen (19) years of age on the coverage effective date or renewal date may be covered under the Supplemental Family Dental Insurance, if Supplemental Family Dental Insurance is endorsed onto the policy.

~~**Child:** A person under the age of twenty-six (26) years. Depending on the Child's age, an enrolled Child may be covered either on the Pediatric Dental Plan or Supplemental Dental Plan as follows:~~

- ~~— A Child who is less than nineteen (19) years of age on the coverage effective date will be covered on the Pediatric Dental Plan until that Child is nineteen (19) years of age on the renewal date;~~

~~— A Child who is between nineteen (19) and twenty-six (26) years of age on the coverage effective date will be covered on the Supplemental Dental Plan until that Child no longer meets the definition of an Eligible Dependent.~~

**Coinsurance:** The amount of an expense for a Covered Service that we will pay once the deductible is satisfied.

**Covered Dependent:** A Child who is an Eligible Person and who is enrolled in and covered under an active policy of insurance issued to the Policyholder named on the Statement of Coverage.

**Covered Service:** A service or supply listed as a Covered Service and not otherwise limited or excluded by this Policy. A Covered Service must be provided by a doctor of medical dentistry or a doctor of dental surgery, or a denturist.

**Eligible Person:**

- (1) You;
- (2) Your lawful spouse or domestic partner; and
- (3) Your or Your spouse's or domestic partner's child or children, including a natural child, step-child, foster child, lawfully adopted child or child in the process of being adopted, from the date of placement, or any child for whom You have been granted legal custody, provided they are less than twenty-six (26) years of age; or
- (4) A child named in a Qualified Medical Child Support Order will be considered an Eligible Person.

"Eligible Person" also means a dependent child, who upon reaching the termination age, is unable to sustain employment because of a permanent mental or physical handicap and You notify Us in writing within thirty-one (31) days after the termination age, the child will continue to qualify as a dependent under this plan, provided You and the dependent child continue to be insured under this plan, and the child continues to be handicapped and dependent upon You for support. This shall not apply to a dependent child who is beyond the termination age on the date You become eligible for dependent insurance under this Policy.

**Eligible Dependent: Means:**

- ~~(1) Your lawful spouse or domestic partner and~~
- ~~(2) Your or Your spouse's or domestic partner's child or children, including a natural child, step-child, foster child, a lawfully adopted child or child in the process of being adopted from the moment of birth or date of placement, if placement for adoption occurs 30 days or more after the child's birth, or any child for whom You have been granted legal custody, provided they are less than twenty six (26) years of age; or~~
- ~~(3) A child named in a Qualified Medical Child Support Order will be considered a dependent.~~

~~"Eligible Dependent" also means a dependent child, who upon reaching the termination age, is unable to sustain employment because of a permanent mental or physical handicap and You notify Us in writing within thirty one (31) days after the termination age, the child will continue to qualify as a dependent under this plan, provided You and the dependent child continue to be insured under this plan, and the child continues to be handicapped and dependent upon You for support. This shall not apply to a dependent child who is beyond the termination age on the date You become eligible for dependent insurance under this Policy.~~

**Emergency Care:** A dental emergency where an acute disorder of oral health requires dental and/or medical attention, including broken, loose, or evulsed teeth caused by traumas; infections and inflammations of the soft tissues of the mouth; and complications of oral surgery, such as dry tooth socket.

**Family Deductible:** The Family Deductible is satisfied when each of three (3) ~~Insuredcovered members~~ inef Your family satisfy the Annual Deductible. ~~Once the combined costs of services provided by Insuredcovered members~~ inef Your family is equal to the Family Deductible amount, no additional Deductible will be required for other ~~insured~~ family members for the remainder of the Calendar Year.

**Grace Period:** A Grace Period of thirty-one (31) days from the due date will be allowed for payment of each premium after the first. ~~This coverage will remain in effect during the Grace Period; provided the premium is paid before the end of the Grace Period.~~

**Insured:** ~~The Subscriber or any Eligible Dependent of a Subscriber~~ An Eligible Person who is enrolled in and covered under the Policy.

**Medically Necessary:** The determination process that may include, and not limited to, the evaluation of the effectiveness and benefit of a dental service or supply for the individual patient based on scientific evidence considerations, up-to-date and consistent professional standards of care, convincing expert opinion and a comparison to alternative interventions, including interventions, and the cost effectiveness of such service or supply. Medical necessity may be obtained by applying an Advance Notice of Treatment.

**Network Provider:** A dental care professional that is contracted with Us and is part of the Network shown on the Schedule of Benefits.

**Out-of-Pocket Maximum:** The total amount of expenses related to Covered Services, in addition to the Deductible, that must be paid on behalf of an Insured on an Annual basis.

**Out-of-Network Provider:** A dental care professional that is not a Network Provider.

**Policy Effective Date:** The date shown on the Statement of Coverage as the Policy Effective Date.

**Statement of Coverage:** The proof of insurance issued to an individual insured under the Policy, outlining the insurance benefits and principle provisions applicable to the member.

~~**Subscriber:** The primary insured person as shown on the Statement of Coverage, and the person paying premiums to provide coverage on behalf of the Insured; may be the Insured.~~

**Usual, Reasonable and Customary:** The charge for health care that is consistent with the average rate or charge for identical or similar services in a certain geographical area.

**You or Your:** Means the ~~Insured~~ Policyholder.

## PART 5 - COVERAGE EFFECTIVE AND TERMINATION DATES

### EFFECTIVE DATE

**Coverage:** The Insured's coverage will take effect on the Insured's Effective Date as shown on the Statement of Coverage.

### TERMINATION OF INSURANCE

The Insured's coverage will stop on the earliest of the following dates:

- (1) the last day of the month in which the Insured stops being a member of a class eligible for insurance under this plan;
- (2) the last day of the month in which the Subscriber/Policyholder requests coverage be cancelled;
- (3) If We do not receive payment before a Grace Period expires, the Policy is terminated as of the last date for which the premium is paid in full.~~the day before the due date of any premium that remains unpaid at the end of the Grace Period;~~
- (4) the date the Policy terminates;
- (5) the last day of the month in which an Insured stops meeting the definition of Eligible Dependent Person; or
- (6) the day the Insured moves outside of the service area for Insured's selected network. Insured may request a plan change if Insured moves within an area where an alternate plan is available.

BEST Life will notify Subscriber/Policyholder in writing by mail to Policyholder's/Subscriber's last known address at least thirty-ninety (930) days prior to the effective date of the termination of this insurance coverage.

## PART 6 – PREMIUM PROVISIONS

**Premium Payments:** Renewal premiums are payable to the Company. The payment of any premium shall not continue this Policy in force beyond the next premium due date, except as provided in the Grace Period provision.

**Changes in Premiums:** We may change the amount of the required premium due from the Policyholder by giving the Policyholder at least forty-five (45) days advance written notice. During the first twelve (12) months, We will not change the amount of the required premium.

**Grace Period:** This Policy has a thirty-one (31) day Grace Period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following thirty-one (31) days. If billed premium is received by Us d~~During the Grace Period, this Policy will remain in force. If the required premium is not paid by the end of this Grace Period, the Policy is terminated as of the last date for which the premium is paid in full.~~this Policy will lapse as of the end of the Grace Period.

**Reinstatement:** If any renewal premium is not paid by the end of the Grace Period, coverage under this Policy will be terminated. However, BEST Life will reinstate this Policy, without requiring an application for reinstatement, as long as premium is paid for at least the sixty (60) days prior to the date of reinstatement. The reinstated Policy will cover only loss resulting from an accidental injury sustained after the date of reinstatement and loss due to sickness beginning ten (10) days after reinstatement. In all other respects the insured and BEST Life shall have the same rights as they had under the Policy immediately before the due date of the defaulted premium, subject to conditions and provisions of the Policy.

## PART 7 – GENERAL PROVISIONS

**Clerical Error:** Clerical error by the Policyholder shall not invalidate insurance otherwise validly in force nor continue insurance otherwise validly terminated.

**Third Party Responsibility:** If an Insured is injured or becomes ill through the act or omission of

another person, to the extent that the Insured recovers medical expenses for the same Injury or Illness from a third party or its insurer, We will be entitled to a repayment of any remuneration in excess of benefits paid under the Policy due to the same Injury or Illness, and after the Insured is fully compensated for his or her loss. We may file a lien for such repayment. Upon request, the Insured must complete and return the required forms to Us.

The repayment agreement will be binding upon the Insured, or the legal representative of a minor or incompetent, whether:

- (1) the payment received from the third party, or its insurer, is the result of:
  - (1) legal judgment;
  - (2) an arbitration award;
  - (3) a compromise settlement;
  - (4) any other arrangements; or
- (2) the third party or its insurer had admitted liability for the payment; or
- (3) the medical expenses are itemized in the third party payment.

**Entire Contract; Changes:** The Policy, including the endorsements, riders, application and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions. We will consider any statement made by the Insured or the Policyholder, in the absence of fraud, as a representation and not a warranty.

**Underwriting Decisions:** If, for any reason, We cannot accept Your application for coverage, We will communicate Our decision to You in writing with the reasons supporting Our decision.

**Notification to Insureds:** BEST Life will notify ~~Subscriber~~Policyholder in writing by mail to ~~Subscriber~~Policyholder's last known address at least thirty (30) days prior to the effective date of the termination of ~~Yy~~our insurance, a change in ~~Yy~~our premium, a change in eligibility or a change in ~~Yy~~our benefits.

**Right to Contest:** After this Policy has been in force for a period of two (2) years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application. No claim for loss incurred or disability (as defined in the Policy) commencing after two (2) years from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Policy.

**Notice of Claim:** We must receive written notice within twenty (20) days after a claim starts or as soon as reasonably possible. The notice shall be sent to BEST Life and Health Insurance Company at [2505 McCabe Way, Irvine, California 92614] or given it to Our agent.

**Claim Forms:** When We receive a notice of claim, We will send forms for filing the claim. If the ~~Subscriber~~Policyholder or Insured do not receive these forms within fifteen (15) days, the ~~Subscriber~~Policyholder or Insured may send Us a written statement to satisfy this requirement. This statement should include the nature and extent of the claim and be sent to Us within the time stated in the Proof of Loss provision.

**Proof of Loss:** We must receive written proof of loss within ninety (90) days of a claim. If it is not

possible for proof to be provided within the ninety (90) days, We will not deny a claim for this reason if We receive the proof as soon as possible. ~~Failure to give notice or file proof of loss as required shall not bar recovery under the Policy unless We are prejudiced by that failure. In any event, We must receive proof no later than one year from the time specified, unless Subscriber is legally incapacitated.~~

**Time of Payment of Claims:** Indemnities payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this Policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

**Payment of Claims:** All payments will be made to ~~Subscriber~~Policyholder or Insured's provider.

**Legal Actions:** A legal action may not be brought against Us before sixty (60) days, or after three (3) years, from the date written proof of loss is required to be given.

**Time Limit on Certain Defenses:** After this Policy has been in force for two (2) years, We will not use any statements made in the application of the Policyholder to void the Policy. After an Insured Person has been covered under this Policy for two (2) years, We will not use any statement made in the Insured Person's enrollment form to defend a claim.

**Misstatement of Age:** If the age of any individual covered under the Policy has been misstated, there shall be an adjustment of premium for the Policy so that there shall be paid to Us the premium for the coverage of such individual at his or her correct age, and the amount of the insurance coverage shall not be affected.

**Worker's Compensation:** The Policy is not in lieu of and does not affect any requirement for coverage by Worker's Compensation Insurance.

**Conformity with State Statutes:** Any provisions of the Policy which are in conflict with the statutes of the state in which the Policy was issued or delivered will be changed to conform to such laws.

**Waiver of Rights:** If We fail to enforce any provision of the Policy, such failure will not affect Our right to do so at a later date, nor will it affect Our right to enforce any other provision of the Policy.

**Inspection of Policy:** The Policy is in the possession of the Policyholder. It may be inspected at any time during business hours at the office of the Policyholder.

**Duty to Cooperate:** As a condition precedent to the payment of benefits hereunder, the ~~Subscriber~~Policyholder and Insured are required to cooperate with Us by providing all information reasonably required to accurately process a claim. Any failure to provide necessary information may result in a denial of benefits for the claim.

## **PART 8 – FILING A DENTAL CLAIM**

**HOW TO FILE A CLAIM:** Claim forms may be obtained from [the BEST Life website located at [www.bestlife.com](http://www.bestlife.com), click on "Forms"].

Submit claims to [BEST Life and Health Insurance Company], [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

For questions about a claim payment, contact BEST Life's Customer Service at [1-800-433-0088 or at [cs@bestlife.com](mailto:cs@bestlife.com), Monday through Friday, 7 am to 5 pm Pacific Time].

**CLAIMS DENIAL PROCEDURE:** Any denial of a claim for Benefits will be explained in writing. The explanation will include (a) the specific reason for the denial, (b) reference to the plan provision upon which the denial was based, (c) a description of any additional information that might be required to provide and an explanation of why it is needed, and (d) an explanation of the plan's claim review procedure.

**APPEALING THE DENIAL OF A CLAIM:** You or an authorized representative You appoint to assist or represent You, may appeal any denial of a claim, in whole or in part, for Benefits by filing a written request for a review. The request must include all reasons You believe the initial decision was incorrect and all documentation supporting Your appeal, to BEST Life and Health Insurance Company, Attn: Appeals, [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

A request for a review must be filed within one-hundred and eighty (180) days after the date on which we issue the written notice of denial of a claim. BEST Life and Health Insurance Company will provide an appeal determination not later than sixty (60) days after receipt of a request for review. If there are special circumstances, the decision will be made as soon as possible, but no later than fifteen (15) days after receipt of the request for review. The appeal determination will be in writing and will include specific reasons for the decision. This decision shall also include specific references to the Policy provisions on which the decision was based.

If we at BEST Life and Health Insurance Company have not satisfactorily resolved ~~Yy~~our dispute, ~~Yy~~ou may contact the Department of Insurance at:

Utah Insurance Department  
Office of Consumer Health Assistance  
Suite 3110  
State Office Building  
Salt Lake City, UT 84114  
Telephone: 801-538-3077  
Toll Free: 800-439-3850  
Email: [healthappeals.uid@utah.gov](mailto:healthappeals.uid@utah.gov)



## **[ENDORSEMENT - SUPPLEMENTAL FAMILY DENTAL INSURANCE]**

If the Policyholder selected Family Dental Coverage, then this Endorsement modifies, supplements, and becomes a part of the Policy. It provides coverage under the terms of the Policy to enrolled Eligible Persons until they reach maximum eligibility age. Except as expressly provided in this Endorsement, all terms and conditions of the Certificate remain unchanged and in full force and effect.

### **Dental Plan Schedule of Benefits** **For all Eligible Persons** **until they reach maximum eligibility age**

<u><b>Benefits Description</b></u>	<u><b>[BESTOne Dental] [Advantage][Plus][Basic] Plan</b></u>	
	<u><b>In-Network [Network]</b></u>	<u><b>Out-of-Network</b></u>
<u><b>Annual Maximum</b></u>	<u><b>[\$500 – 3,500]</b></u>	
<u><b>Annual Deductible</b></u> <u>(Applies to Basic and Major) – 3 Deductible</u> <u>Maximum per Family</u>	<u><b>[\$0-100]</b></u>	
<u><b>Basic Services Coinsurance</b></u> <u>Routine oral exam, cleanings, X-rays]</u>	<u><b>[100-70]%</b></u>	<u><b>[100-70]%</b></u>
<u><b>Intermediate Services Coinsurance</b></u> <u>Filings (amalgam, porcelain &amp; plastic), anterior &amp;</u> <u>posterior composites, anesthesia (general or</u> <u>intravenous sedation), emergency palliative</u> <u>treatment, pathology]</u>	<u><b>[90-50]%</b></u>	<u><b>[80-20]%</b></u>
<u><b>Major Services Coinsurance</b></u> [ <u>Crowns &amp; gold fillings, inlays, onlays &amp; pontics,</u> <u>[implants,] fixed bridges, complete &amp; partial</u> <u>dentures]</u>	<u><b>[60-0]%</b></u>	<u><b>[50-0]%</b></u>
<u><b>[Endodontic Services</b></u>	<u><b>[Basic][Major]</b></u>	
<u><b>[Periodontic Services</b></u>	<u><b>[Basic][Major]</b></u>	
<u><b>[Oral Surgery Services</b></u>	<u><b>[Basic][Major]</b></u>	
<u><b>[Major Services Waiting Period</b></u>	<u><b>12 months]</b></u>	

### **COVERED SERVICES ON SUPPLEMENTAL DENTAL PLAN**

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Policy.

**CLASS A – Basic Services** - Basic Services shall not duplicate those services covered under the Pediatric Dental Insurance Plan. Additional basic benefits may be available to supplement the Pediatric Dental Insurance Plan for Insureds under the age of 19:

- (1) Routine oral examination and diagnosis not more often than twice every twelve (12) months per individual;
- (2) Bitewing x-rays not more often than once every twelve (12) months per individual;
- (3) Full mouth x-rays or panoramic films are limited to once every five (5) years; any combination of eight (8) or more x-rays (including but not limited to bitewings or periapicals/intraorals)



- will be combined into a full mouth x-ray series;
- (4) Prophylaxis not more often than once every six (6) months per individual.

**CLASS B – Intermediate Services:**

- (1) Pathology;
- (2) All fillings other than lab fabricated restorations (composite fillings limited to permanent anterior and posterior teeth);
- (3) Emergency palliative treatment;
- (4) Limited oral exam not more than once every six months;
- (5) Simple extraction, excluding orthodontic extractions unless a orthodontic benefits are a Covered Dental Expense on this Plan;
- (6) Surgical extraction, including impaction:
- (a) erupted tooth;
- (b) soft tissue impaction;
- (c) partial bony impaction;
- (d) complete bony impaction;
- (7) General anesthesia or intravenous sedation when required for complex oral surgical procedures (partial and complete bony impacted extractions only);
- (8) Periodontics (tissues and gums);
- (9) Periodontal exam (not in addition to a routine oral exam);
- (10) Periodontal maintenance (limited to once every six (6) months per individual following active periodontal treatment) and not on the same visit as a routine prophylaxis;
- (11) Periodontal scaling and root planing (limited to once every 36 months and to two (2) quadrants per visit, and not in addition to a routine prophylaxis);
- (12) Endodontics (pulp capping and root canal); and
- (13) Oral surgery:
- (a) root recovery (surgical removal of residual root);
- (b) oral antral fistula closure;
- (c) removal of a dentigerous or odontogenic cyst;
- (d) incision and drainage of an abscess;
- (e) removal of lateral exostosis;
- (f) frenulectomy.

**CLASS C - Major Services:**

- (1) Inlays, onlays, crowns and other lab fabricated restorations (not including veneers);
- (2) Porcelain, porcelain fused to metal, or full gold crowns on permanent teeth;
- (3) Full or partial dentures or fixed bridgework or adding teeth to an existing denture, if required because of loss of functional natural teeth while the person is covered for this Benefit. The work must be done within twelve (12) months after the extraction and while this coverage is in force;
- (4) Replacement or alteration of full or partial dentures or fixed bridgework caused by the following while coverage is in force:
- (a) accidental injury requiring oral surgical treatment, or
- (b) oral surgical treatment involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus or redundant tissue, provided the replacement or alteration is done within twelve (12) months of the injury or surgical treatment.
- (5) Replacement of a full denture or bridgework if the replacement is made more than seven (7) years after the date of installation, unless:
- (a) such replacement is made necessary by the initial extraction of an adjoining functional natural tooth; or
- (b) the prosthesis, while in the oral cavity, has been damaged beyond repair as a result of a

- non-chewing injury while covered;
- (6) Repair or relines of dentures and bridgework;
  - (7) Implants, as an alternative to a fixed prosthetic, (limited to once in a lifetime per site). The cost of the fixed prosthetic will be applied to the total value of the implant and implant-related procedures, not to exceed the cost of the fixed prosthetic:
    - (a) the surgical placement of endosteal implant body including healing cap, where the bone and soft tissues are sound and healthy;
    - (b) implant supported prosthetics;
    - (c) eposteal and transosteal implants will be covered at the cost of the endosteal implant (if performed, member is responsible for additional fees);
    - (d) bone grafting and tooth extractions, provided the work is done while this coverage is in force;
    - (e) implant maintenance].

### **EXCLUSIONS ON SUPPLEMENTAL DENTAL PLAN**

The following exclusions are not Covered Services. No payments will be made by Us for these services:

- (1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;
- (2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
- (3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
- (4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;
- (5) Services and supplies begun and not completed prior to the patient's effective date, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
- (6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
- (7) Pulp capping, if in conjunction with the installation of inlays, onlays or crowns and fillings or other lab fabricated restorations; including but not limited to inlays, onlays and crowns, preventative tests and examinations diagnostic casts and oral cancer screenings, and expenses incurred for sedative fillings, including charges for prescribed drugs, pre-medication or analgesia;
- (8) The initial installation of a prosthetic device (a fixed bridge, implant, or denture), including crowns and inlays which form abutments, to replace teeth missing before You were covered under the Policy, except when it also replaces a tooth that is extracted while covered unless such installation commences after You have remained continuously covered under this plan for at least three years immediately prior to the date such installation commences;
- (9) Implants, implant services and implant supported prosthetics;
- (10) Expenses incurred for veneers and related procedures;
- (11) Replacement of a lost or stolen or discarded prosthetic device;
- (12) Adjustment, repairs or relines of prostheses for a period of one (1) year from initial placement if the prostheses were paid for under this plan;
- (13) Expenses incurred for a core buildup will only be considered in conjunction with a crown;
- (14) If multiple endodontic treatments are necessary on the same tooth within a period of one

- (1) year, the allowance will be made for only one (1) procedure;
- (15) X-rays are considered an integral part of the endodontic procedure rather than a separate service and are therefore not eligible for benefits;
  - (16) The extraction of immature erupting third molars and non-pathologic, asymptomatic third molar extractions;
  - (17) Expenses for gross debridement allowed one time at the beginning of the periodontal treatment plan prior to pocket depth charting;
  - (18) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
  - (19) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are a Covered Dental Expense on this Plan;
  - (20) Surgical procedures incidental to orthodontic treatment, including but not limited to, extraction of teeth solely for orthodontic reasons, exposure of impacted teeth, correction of micrognathia or macrognathia, or repair of cleft palate;
  - (21) Charges for service provided for temporomandibular joint dysfunction (TMJ);
  - (22) Expenses incurred for congenital or developmental malformations;
  - (23) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
  - (24) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits;
  - (25) Chemotherapeutic agents and any other experimental procedures;
  - (26) Charges in excess of the In-Network Provider Fee Schedule for the services in the area where treatment was received or charges in excess of the Calendar Year Maximum amount stated in the "Schedule of Dental Benefits" section of this Plan;
  - (27) Expenses that are applied toward satisfaction of a Deductible, if any;
  - (28) Services and supplies performed outside of the United States of America;
  - (29) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, Your lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;
  - (30) Expenses for services for which You would not legally have to pay if there were no insurance;
  - (31) Services not completed on or before the date of termination;
  - (32) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
  - (33) Any service or procedure not commonly found within the scope of practice by a licensed dentist. Such procedures are identified within the current Common Dental Terminology (CDT Codes) published by the American Dental Association;
  - (34) Expenses incurred for services covered on a pediatric only dental plan.]



Underwritten by BEST Life and Health Insurance Company

State: Tennessee

Filing Company:

BEST Life and Health Insurance Company

TOI/Sub-TOI: H10I Individual Health - Dental/H10I.000 Health - Dental

Product Name: Stand Alone Dental - Individual Market

Project Name/Number: Form Filing/Exchange Products

## Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
07/31/2013	Replaced 08/12/2013	Form	Individual Market Pediatric Dental Group Policy	08/09/2013	IFD-PPO-POL-0113TN(3).pdf (Superseded)
07/31/2013	Replaced 08/12/2013	Supporting Document	redline	07/31/2013	IFD-PPO-POL-0113TN(2)-redline.pdf (Superseded)
07/18/2013	Replaced 08/12/2013	Supporting Document	Response to Objections to Rates	07/26/2013	Determination of Age Factors.pdf Summary of Area Factors - TN 06242013.pdf Summary of Normalized Paid to Children 0-19.xlsx PM_FAQ10v2_508cr_052313.pdf
06/13/2013	Replaced 08/12/2013	Form	Individual Market Pediatric Dental Group Policy	07/31/2013	
06/13/2013	Replaced 08/12/2013	Form	Individual Market Family or Child Dental Policy	07/26/2013	GAD-IM-PPO-POL-0113TN_redline.pdf (Superseded) IFD-PPO-POL-0113TN.pdf (Superseded)
06/13/2013	Replaced 08/12/2013	Form	Individual Market Family or Child Outline of Coverage	08/09/2013	IFD-PPO-OC-0113TN.pdf (Superseded)
04/30/2013	Replaced 08/12/2013	Rate	ACTUARIAL MEMORANDUM	07/18/2013	Actuarial Memorandum TN - Individual April 30 2013.pdf (Superseded)
04/30/2013	Replaced 08/12/2013	Rate	PEDIATRIC RATE CALCULATIONS	07/18/2013	Individual Pediatric - TN 04302013.pdf (Superseded)

SERFF Tracking #:

BLHI-129004054

State Tracking #:

H-130559

Company Tracking #:

FORM FILING

**State:** Tennessee**Filing Company:**

BEST Life and Health Insurance Company

**TOI/Sub-TOI:** H10I Individual Health - Dental/H10I.000 Health - Dental**Product Name:** Stand Alone Dental - Individual Market**Project Name/Number:** Form Filing/Exchange Products

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
04/30/2013	Replaced 08/12/2013	Rate	ADULT RATE CALCULATIONS	07/18/2013	Individual Supplemental - TN 04302013.pdf (Superceded)
04/27/2013	Replaced 08/12/2013	Form	Individual Market Pediatric Dental Group Policy	06/13/2013	GPD-IM-PPO-POL-0113TN.pdf (Superceded)
04/27/2013	Approved 08/12/2013	Form	Individual Market Pediatric Dental Certificate	06/13/2013	GPD-IM-PPO-CERT-0113TN.pdf (Superceded)
04/27/2013	Replaced 08/12/2013	Form	Individual Market Pediatric Dental Statement of Variability	06/13/2013	GPD-IM-PPO-SOV-0113TN.pdf (Superceded)
04/27/2013	Replaced 08/12/2013	Form	Individual Market Adult Dental Policy	06/13/2013	GAD-IM-PPO-POL-0113TN.pdf (Superceded)
04/27/2013	Replaced 08/12/2013	Form	Individual Market Adult Dental Certificate	06/13/2013	GAD-IM-PPO-CERT-0113TN.pdf (Superceded)
04/27/2013	Replaced 08/12/2013	Form	Individual Market Adult Dental Variability Statement	06/13/2013	GAD-IM-PPO-SOV-0113TN.pdf (Superceded)

**BEST Life and Health Insurance Company**  
[2505 McCabe Way  
Irvine, California 92614]

A STOCK COMPANY  
(Herein called the Company)

**BEST Life and Health Insurance Company ("BEST Life")** is issuing this Policy in consideration of the accuracy of representations made in Your application and Your payment of premiums for Policy coverage.

**READ YOUR POLICY CAREFULLY:** This Policy is a legal contract between You (owner of this Policy) and Us.

**GOVERNING JURISDICTION:** The Policy is issued in the State of Tennessee. It shall be construed in accordance with the laws of the issuing State.

**NOTICE OF TEN DAY RIGHT TO EXAMINE:** We want You to fully understand and be satisfied with the insurance coverage. If for any reason You are not satisfied, You may return this Policy to Your agent or to Our home office within ten (10) days of receipt and Your premium will be fully refunded. Coverage will then be void retroactive to the Insurance Effective Date.

**RENEWAL AND PREMIUM PAYMENT PROVISIONS:** You may renew this Policy for additional coverage periods by paying the premium when due or within the Grace Period until the Insureds reach the maximum eligibility age. Each period of coverage runs from premium due date to premium due date. We reserve the right to change premiums. Any such change will be made according to the table of premium rates that will apply to all policies with the same form and class in Your State. All future renewal premiums will be based on Your original issue age. We will notify You of any premium rate increase at least sixty (60) days in advance. We cannot cancel this Policy while it is in force.

**IN WITNESS WHEREOF,** We have caused this Policy to be signed by Our President and Our Secretary. This Policy takes effect at 12:01 a.m. at Your residence on its Effective Date. This Policy terminates at 12:01 a.m. on the date any renewal premium is due and not paid, subject to the Grace Period.

[



II



**President**

**Secretary**

**Dental PPO Insurance Policy**



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**This Policy Is Not Valid  
Unless There Is a Complete Statement of Coverage**

**Statement of Coverage**

**DENTAL**

**INSURANCE POLICYHOLDER NAME:** [JOHN D. DOE]  
**POLICY EFFECTIVE DATE:** [01/01/2014]

**INSURED NAME(S) AND EFFECTIVE DATE(S):**

[JANE DOE                      01/01/2014]  
[JON DOE                      01/01/2014]

[PLAN:                                      [PPO HIGH]  
DEDUCTIBLE:                              [\$50]  
ANNUAL MAXIMUM: [\$1,000]

PEDIATRIC DENTAL PLAN: [PPO HIGH]  
DEDUCTIBLE:                              [\$50]  
OUT OF POCKET MAXIMUM: [\$700]

**POLICY NO.:**                      [XXXXXXXXXX]

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## PART 1 - SCHEDULE OF BENEFITS

This Policy is made valid on the effective dates shown for the listed Insureds on the Statement of Coverage.

Covered Services received by Insured from a Network Provider are reimbursed at the Network Provider's contracted Fee Schedule. Covered Services received by Insured from an Out-of-Network Provider are reimbursed at the [80th or 90th] percentile of a Usual, Reasonable and Customary schedule. All Covered Services are subject to Cost Sharing as shown on this Schedule of Benefits.

### [Pediatric Dental Plan Schedule of Benefits For Children to Age 19]

	<b>[BEST Life Child Dental] [Plus] Pediatric Dental Plan</b>	
<b>Procedure Categories</b>	<b>In-Network [Network Name]</b>	<b>Out-of-Network</b>
<b>Out-of-Pocket Maximum</b>	\$700 for 1 Child \$1,400 for 2 or more Children	\$700 for 1 Child \$1,400 for 2 or more Children
<b>Annual Deductible</b> – Applies to [Preventive, services received Out-of-Network as well as] Basic and Major services received In-Network or Out-of-Network	\$[0][200]	\$[50][200]
<b>Basic Services Coinsurance</b> [ – Exams, cleanings, sealants, fluoride treatment, x-rays]	100%	[90][60]%
<b>Intermediate Services Coinsurance</b> [ – Fillings]	70%	[60][40]%
<b>Major Services Coinsurance</b> [ – Crowns & casts, prosthodontics, endodontics, periodontics, oral surgery]	50%	[40][20]%
<b>Medically Necessary Orthodontic Services Coinsurance</b>	50% [24 Month Wait]	50% [24 Month Wait]

## **PART 2 - BENEFITS AND EXCLUSIONS**

### **COVERED SERVICES ON PEDIATRIC DENTAL PLAN**

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Policy.

#### **Class I – Preventive and Diagnostic Procedures Include:**

- (1) Prophylaxis not more often than once every six (6) months;
- (2) Topical application of fluoride (excluding prophylaxis) not more often than twice every twelve (12) months;
- (3) Topical fluoride varnish not more often than twice every twelve (12) months;
- (4) Sealants not more often than once per tooth in a thirty-six (36) month period and limited to unrestored permanent molars for individuals under age nineteen (19);
- (5) Space maintainers, including re-cementation, for individuals under age nineteen (19) (excluding removal of fixed space maintainer);
- (6) Periodic oral evaluation not more often than once every six (6) months;
- (7) Limited oral evaluation (problem focused) not more often than once every six (6) months;
- (8) Comprehensive oral evaluation not more often than once every six (6) months;
- (9) Comprehensive periodontal evaluation not more often than once every six (6) months;
- (10) Intraoral complete X-rays or panoramic film not more often than once in a 60-month period;
- (11) Bitewing X-rays not more often than one set every six (6) months;
- (12) Single film intraoral periapical or occlusal;
- (13) Palliative treatment of dental pain (minor procedure);

#### **Class II – Basic Procedures Include:**

- (1) Amalgams, resin-based composites, re-cement inlays, re-cement crowns, protective restoration, pin retention;
- (2) Prefabricated stainless steel crowns not more often than once per tooth in a sixty (60) month period for individuals under age fifteen (15);
- (3) Therapeutic pulpotomy (excluding restoration) if a root canal is not performed within forty-five (45) days of the pulpotomy;
- (4) Partial pulpotomy for apexogenesis limited to permanent tooth with incomplete root development, if a root canal is not performed within forty-five (45) days of pulpotomy;
- (5) Pulpal therapy (excluding final restoration) once per tooth per lifetime, limited to primary incisor teeth for individuals up to age six (6), and limited to primary molars and cuspids for individuals up to age eleven (11);
- (6) Periodontal scaling and root planning, per quadrant, not more often than once every twenty-four (24) months;
- (7) Periodontal maintenance not more often than four in a twelve (12)-month period, combined with adult prophylaxis after the completion of active periodontal therapy;
- (8) Adjustment and repair of complete or partial dentures;
- (9) Rebase and reline not more often than once in a thirty-six (36) month period, six (6) months after initial installation;
- (10) Tissue conditioning;
- (11) Recement fixed partial denture
- (12) Fixed partial denture repair, by report;
- (13) Oral surgery;

- a. extraction for erupted tooth or exposed root;
- b. surgical removal of erupted tooth;
- c. removal of impacted tooth;
- d. removal of residual tooth roots;
- e. coronectomy;
- f. tooth reimplantation;
- g. surgical access of unerupted tooth;
- h. alveoloplasty;
- i. removal of exostosis;
- j. incision and drainage of abscess;
- k. suture of recent small wounds up to five (5) cm
- l. excision of pericoronal gingival;

**Class III – Major Procedures Include:**

- (1) Detailed and extensive oral evaluation;
- (2) Inlays, onlays, crowns, core buildup, including any pins, prefabricated post and core in addition to crown, limited to one per tooth every sixty (60) months;
- (3) Endodontics (root canal)
- (4) Gingivectomy or gingivoplasty, four (4) or more teeth not more often than once every thirty-six (36) months;
- (5) Gingival flap procedure, four (4) or more teeth not more often than once every thirty-six (36) months;
- (6) Osseous surgery, four (4) or more contiguous teeth or bounded teeth spaces per quadrant, not more often than once every thirty-six (36) months;
- (7) Full mouth debridement limited to one (1) per lifetime;
- (8) Complete and partial dentures, including abutments, pontics, onlays, retainers and crowns, not more often than once every sixty (60) months (excludes interim dentures);
- (9) Implants and implant services once every sixty (60) months only if medically necessary;
- (10) Occlusal guard not more often than once in twelve (12) months for individuals thirteen (13) and older with predetermination only;
- (11) General anesthesia or IV sedation;
- (12) Consultation by dentist or physician other than the dentist providing treatment;
- (13) Therapeutic drug injection with predetermination;
- (14) Treatment of post-surgical complications with predetermination.

[**Note:** Unless the twenty-four (24) month waiting period requirement for Medically Necessary Orthodontic services has been met, the services below are not covered benefits for any treatment that began during the twenty-four (24) month period immediately following Your effective date of coverage.]

**Class IV – Medically Necessary Orthodontic Procedures Include:**

- (1) For orthodontia services associated with the repair of cleft palate and palate or other severe craniofacial defects or injury for which the function of speech, swallowing or chewing is restored;
- (2) Requires predetermination; and
- (3) Coverage includes diagnosis, treatment plan, anticipated treatment time and cost estimate.

**EXCLUSIONS ON  
PEDIATRIC DENTAL PLAN**

The following exclusions are not Covered Services. No payments will be made by Us for these services:

- (1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;
- (2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
- (3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
- (4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;
- (5) Services and supplies started and not completed before the patient was covered under this Plan, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
- (6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
- (7) Space maintainers;
- (8) Sealants if re-sealed within a five (5) year period;
- (9) Retreatment of a previous root canal or apicoectomy/periradicular surgery;
- (10) Elective tooth extractions;
- (11) Separate payments for open and drain palliative procedure when the root canal is completed on the same date of service;
- (12) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are defined as a Covered Dental Expense;
- (13) Charges in excess of Usual, Reasonable and Customary charges amount stated in the "Schedule of Benefits" section of this Plan, or in excess of the Preferred Provider Fee Schedule;
- (14) Charges for service provided for temporomandibular joint dysfunction (TMJ);
- (15) Expenses incurred for congenital or developmental malformations, except as defined as a Covered Orthodontic Expense;
- (16) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits, except as defined as a Covered Orthodontic Expense;
- (17) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
- (18) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, the patient's lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;
- (19) Expenses for services for which the patient would not legally have to pay if there were no insurance, unless mandated by the State;
- (20) Services not completed on or before the date of termination;
- (21) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
- (22) Expenses that are applied toward satisfaction of a Deductible, if any;
- (23) Any service or procedure not commonly found within the scope of practice by a licensed dentist;
- (24) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
- (25) Chemotherapeutic agents and any other experimental procedures;
- (26) Expenses incurred for veneers and related procedures;
- (27) Services and supplies performed outside of the United States of America.

## **PART 3 - LIMITATIONS AND COST SHARING**

### **ACCESS TO CARE**

#### **Using a Network Provider:**

BEST Life offers Insureds the option to save on out-of-pocket costs when care is provided by a Network Provider. A listing of General Dentists and Specialists is available. To find a Network Provider, please refer to the Network information provided on the ID Card.

#### **How to Select a Dentist:**

Insureds on this Plan may obtain dental services from any licensed dental professional in the United States. To use the Plan, Insureds may directly contact the dentist of their choice and make an appointment. Insureds are advised to bring their ID Card to their appointment. The dentist may require a copy of the Insured's ID Card to confirm eligibility on this Plan.

#### **How to Obtain a Referral:**

A dentist may determine that an Insured requires treatment from a dental provider that specializes in a type of dentistry (Specialist). The Insured does not need to contact BEST Life for a referral. The Insured can directly contact the Specialist to make an appointment. The Specialist may require information from the Insured's dentist to determine a treatment plan and may contact the dentist directly.

### **ADVANCE NOTICE OF DENTAL TREATMENT**

Policyholder or Insured should submit Advance Notice of Dental Treatment before treatment commences in order to obtain Predetermination of Covered Services, including services that are medically necessary. If dental services are performed without such Predetermination, We reserve the right to deny any claim submitted with respect to such Covered Services; provided however, that predetermination is not required for:

- (1) Covered Services for which the related expense is less than \$500 during any course of treatment ("course of treatment" means one treatment or one of a planned series of treatments resulting from dental examination);
- (2) Emergency treatment; or
- (3) Oral examination and prophylaxis.

Predetermination is required for the following dental services for children:

- (1) Medically necessary services or supplies;
- (2) Panoramic film for children under age six (6);
- (3) Periodontal scaling and root planing;
- (4) Occlusal orthotic devices;
- (5) Appliance therapy;
- (6) Orthodontia, including preorthodontic treatment visit.

Predetermination is required for the following dental services for adults and children 19 or older:

- (1) Crowns, Anterior, except with posts or root canal;
- (2) Crowns, 2 or more Posterior, except with posts or root canal;
- (3) Inlays or Onlays, 2 or more, except with posts or root canal;
- (4) Laminates;
- (5) Anterior composites;



- (6) 2 or more multiple surfaces;
- (7) Bridges – initial or replacement;
- (8) Eligible partial dentures – initial or replacement;
- (9) Periodontal surgery over \$500;
- (10) Full bony impactions, 2 or more.

We will have thirty (30) days to furnish the provider with an Explanation of Benefits demonstrating whether the proposed treatment will be a Covered Service under this Policy.

## **DEDUCTIBLES**

**Annual Deductible:** The Annual Deductible shown in the Schedule of Dental Benefits will apply separately to each Insured. Each Insured must accumulate eligible expenses equal to the deductible amount.

## **ALTERNATIVE PROCEDURES**

If more than one treatment plan exists for a dental procedure, covered dental expenses will be based on the least expensive procedure that will produce a result that meets professionally recognized standards. If the Insured's provider elects the more expensive treatment, the Insured or Policyholder shall be responsible for any charges that are greater than the covered expense for the less expensive treatment.

## **PART 4 - DEFINITIONS**

**Annual:** The twelve (12) month period beginning on the effective date of the Certificate and ending on the termination date of the Certificate. The Annual time frame will be applied to the Deductible and the Annual Maximum amount.

**Annual Deductible:** The amount each Insured must satisfy before Benefits are payable by Us. To satisfy the Annual Deductible, the Insured must accumulate expenses for Covered Services equal to the Deductible amount shown on the Schedule of Benefits.

**Annual Maximum:** The maximum amount BEST Life will reimburse for covered services during a twelve (12) month period for each Insured person. Once the full Annual Maximum amount has been paid, no additional services will be reimbursed for the remainder of that year. The

**Child:** A dependent child who meets the definition of Eligible Person may be enrolled and covered under this Policy, as follows:

1. A child who is less than nineteen (19) years of age on the coverage effective date will be covered on the Pediatric Dental Plan until that child is nineteen (19) years of age on the renewal date;
2. A child who is older than nineteen (19) years of age on the coverage effective date or renewal date may be covered under the Supplemental Family Dental Insurance, if Supplemental Family Dental Insurance is endorsed onto the policy.

**Coinsurance:** The amount of an expense for a Covered Service that we will pay once the deductible is satisfied.

**Covered Dependent:** A Child who is an Eligible Person and who is enrolled in and covered under an active policy of insurance issued to the Policyholder named on the Statement of Coverage.

**Covered Service:** A service or supply listed as a Covered Service and not otherwise limited or excluded by this Certificate. A Covered Service must be provided by a doctor of medical dentistry or a doctor of dental surgery, or a dentist.

**Eligible Person:**

- (1) You [to age 65]
- (2) Your lawful spouse or domestic partner [to age 65]; and
- (3) Your or Your spouse's or domestic partner's child or children, including a natural child, step-child, foster child, lawfully adopted child or child in the process of being adopted, from the date of placement, or any child for whom You have been granted legal custody, provided they are less than twenty-six (26) years of age; or
- (4) A child named in a Qualified Medical Child Support Order will be considered an Eligible Person.

"Eligible Person" also means a dependent child, who upon reaching the termination age, is unable to sustain employment because of a permanent mental or physical handicap and You notify Us in writing within thirty-one (31) days after the termination age, the child will continue to qualify as a dependent under this plan, provided You and the dependent child continue to be insured under this plan, and the child continues to be handicapped and dependent upon You for support. This shall not apply to a dependent child who is beyond the termination age on the date You become eligible for dependent insurance under this Policy.

**Family Deductible:** The Family Deductible is satisfied when each of three (3) covered members of Your family satisfy the Annual Deductible. Once the combined costs of services provided by covered members of Your family is equal to the Family Deductible amount, no additional Deductible will be required for other insured family members for the remainder of the Calendar Year.

**Emergency Care:** A dental emergency where an acute disorder of oral health requires dental and/or medical attention, including broken, loose, or evulsed teeth caused by traumas; infections and inflammations of the soft tissues of the mouth; and complications of oral surgery, such as dry tooth socket.

**Grace Period:** A Grace Period of thirty-one (31) days from the due date will be allowed for payment of each premium after the first. This coverage will remain in effect during the Grace Period; provided the premium is paid before the end of the Grace Period.

**Insured:** The Policyholder or any Eligible Dependent of a Policyholder who is enrolled in and covered under the Policy.

**Medically Necessary:** The determination process that may include, and not limited to, the evaluation of the effectiveness and benefit of a dental service or supply for the individual patient based on scientific evidence considerations, up-to-date and consistent professional standards of care, convincing expert opinion and a comparison to alternative interventions, including interventions, and the cost effectiveness of such service or supply. Medical necessity may be obtained by applying an Advance Notice of Treatment.

**Network Provider:** A dental care professional that is contracted with Us and is part of the Network shown on the Schedule of Benefits.

**Out-of-Pocket Maximum:** The total amount of expenses related to Covered Services, in addition to the

Deductible, that must be paid on behalf of an Insured on an Annual basis.

**Out-of-Network Provider:** A dental care professional that is not a Network Provider.

**Policy Effective Date:** The date shown on the Statement of Coverage as the Policy Effective Date.

**Statement of Coverage:** The proof of insurance issued to an individual insured under the Policy, outlining the insurance benefits and principle provisions applicable to the member.

**Usual, Reasonable and Customary:** The charge for health care that is consistent with the average rate or charge for identical or similar services in a certain geographical area.

**You or Your:** Means the Policyholder.

## **PART 5 – ENROLLMENT, EFFECTIVE DATE AND TERMINATION DATE**

### ***ENROLLMENT***

A person eligible as a Policyholder must:

- (1) Enroll all Eligible Persons in accordance with the annual open enrollment period;
- (2) Enroll all Eligible Persons within thirty (30) days of one of the following triggering events:
  - (a) The date on which an Eligible Person loses minimum essential coverage;
  - (b) A Policyholder gains an Eligible Person Child;
  - (c) A person becomes an Eligible Person through marriage, birth, adoption or placement for adoption;
  - (d) An Eligible Person's enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or HHS, or its instrumentalities as evaluated and determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;
  - (e) An enrollee adequately demonstrates to the Exchange that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
  - (f) An Eligible Person gains access to new qualified health plans as a result of a permanent move;
  - (g) An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a QHP or change from one QHP to another one time per month; and
  - (h) An Eligible Person demonstrates that the individual meets other exceptional circumstances.

### ***EFFECTIVE DATE***

Your insurance will become in effect as follows:

- (1) If enrollment is received between the first (1<sup>st</sup>) and the fifteenth (15<sup>th</sup>) day of the enrollment period, coverage will be effective on the first day of the following month; and
- (2) If enrollment is received between the sixteenth (16<sup>th</sup>) and the last day of the enrollment period, coverage will be effective on the first day of the second following month.

### ***TERMINATION DATE***

Coverage may be terminated, as follows:

- (1) You may terminate coverage with appropriate notice.
- (2) We may terminate coverage in the following circumstances:
  - (a) You are no longer eligible for coverage through the Exchange;
  - (b) Non-payment of premiums;
  - (c) Your coverage is rescinded;

- (d) **We terminate or decertify; or**
- (e) **You change insurance carriers during an annual open enrollment period or special enrollment period.**

## **PART 6 –PREMIUM PROVISIONS**

**Premium Payments:** Renewal premiums are payable to the Company. The payment of any premium shall not continue this Policy in force beyond the next premium due date, except as provided in the Grace Period provision.

**Changes in Premiums:** We may change the amount of the required premium due from the Policyholder by giving the Policyholder at least sixty (60) days advance written notice. During the first 12 months, We will not change the amount of the required premium.

**Grace Period:** This Policy has a thirty-one (31) day Grace Period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following thirty-one (31) days. During the Grace Period, this Policy will remain in force. If the required premium is not paid by the end of this Grace Period, this Policy will lapse as of the last paid through date.

**Reinstatement:** If any renewal premium is not paid by the end of the Grace Period, coverage under this Policy will be terminated. However, BEST Life will reinstate this Policy, without requiring an application for reinstatement, as long as premium is paid for at least the sixty (60) days prior to the date of reinstatement. The reinstated Policy will cover only loss resulting from an accidental injury sustained after the date of reinstatement and loss due to sickness beginning ten (10) days after reinstatement. In all other respects the insured and BEST Life shall have the same rights as they had under the Policy immediately before the due date of the defaulted premium, subject to conditions and provisions of the Policy.

## **PART 7 – GENERAL PROVISIONS**

**Clerical Error:** Clerical error by the Policyholder shall not invalidate insurance otherwise validly in force nor continue insurance otherwise validly terminated.

**Third Party Responsibility:** If an Insured is injured or becomes ill through the act or omission of another person, to the extent that the Insured recovers medical expenses for the same Injury or Illness from a third party or its insurer, We will be entitled to a repayment of any remuneration in excess of benefits paid under the Policy due to the same Injury or Illness, and after the Insured is fully compensated for his or her loss. We may file a lien for such repayment. Upon request, the Insured must complete and return the required forms to Us.

The repayment agreement will be binding upon the Insured, or the legal representative of a minor or incompetent, whether:

- (1) the payment received from the third party, or its insurer, is the result of:
  - legal judgment;
  - an arbitration award;
  - a compromise settlement;
  - any other arrangements; or
- (2) the third party or its insurer had admitted liability for the payment; or
- (3) the medical expenses are itemized in the third party payment.

**Entire Contract; Changes:** The Policy, including the endorsements, certificates, riders, application and

the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions. We will consider any statement made by the Insured or the Policyholder, in the absence of fraud, as a representation and not a warranty.

**Underwriting Decisions:** If, for any reason, We cannot accept Your application for coverage, We will communicate Our decision to You in writing with the reasons supporting Our decision.

**Notification to Insureds:** BEST Life will notify Policyholder in writing by mail to Policyholder's last known address at least thirty (30) days prior to the effective date of the termination of your insurance, a change in your premium, a change in eligibility or a change in your benefits.

**Right to Contest:** After this Policy has been in force for a period of two (2) years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application. No claim for loss incurred or disability (as defined in the Policy) commencing after two (2) years from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Policy.

**Notice of Claim:** We must receive written notice within twenty (20) days after a claim starts or as soon as reasonably possible. The notice shall be sent to [BEST Life and Health Insurance Company at 2505 McCabe Way, Irvine, California 92614] or given it to Our agent.

**Claim Forms:** When We receive a notice of claim, We will send forms for filing the claim. If the Policyholder or Insured do not receive these forms within fifteen (15) days, the Policyholder or Insured may send Us a written statement to satisfy this requirement. This statement should include the nature and extent of the claim and be sent to Us within the time stated in the Proof of Loss provision.

**Proof of Loss:** We must receive written proof of loss within ninety (90) days of a claim. If it is not possible for proof to be provided within the ninety (90) days, We will not deny a claim for this reason if We receive the proof as soon as possible. In any event, We must receive proof no later than one year from the time specified, unless Policyholder is legally incapacitated.

**Time of Payment of Claims:** Indemnities payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this Policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

**Payment of Claims:** All payments will be made to Policyholder or Insured's provider.

**Legal Actions:** A legal action may not be brought against Us before sixty (60) days, or after three (3) years, from the date written proof of loss is required to be given.

**Time Limit on Certain Defenses:** After this Policy has been in force for two (2) years, We will not use any statements made in the application of the Policyholder to void the Policy. After an Insured Person has been covered under this Policy for two (2) years, We will not use any statement made in the

Insured Person's enrollment form to defend a claim.

**Misstatement of Age:** If the age of any individual covered under the Policy has been misstated, there shall be an adjustment of premium for the Policy so that there shall be paid to Us the premium for the coverage of such individual at his or her correct age, and the amount of the insurance coverage shall not be affected.

**Worker's Compensation:** The Policy is not in lieu of and does not affect any requirement for coverage by Worker's Compensation Insurance.

**Conformity with State Statutes:** Any provisions of the Policy which are in conflict with the statutes of the state in which the Policy was issued or delivered will be changed to conform to such laws.

**Waiver of Rights:** If We fail to enforce any provision of the Policy, such failure will not affect Our right to do so at a later date, nor will it affect Our right to enforce any other provision of the Policy.

**Inspection of Policy:** The Policy is in the possession of the Policyholder. It may be inspected at any time during business hours at the office of the Policyholder.

**Duty to Cooperate:** As a condition precedent to the payment of benefits hereunder, the Policyholder and Insured are required to cooperate with Us by providing all information reasonably required to accurately process a claim. Any failure to provide necessary information may result in a denial of benefits for the claim.

## **PART 8 – FILING A DENTAL CLAIM**

**HOW TO FILE A CLAIM:** Claim forms may be obtained from [the BEST Life website located at [www.bestlife.com](http://www.bestlife.com), click on "Forms"].

Submit claims to [BEST Life and Health Insurance Company, P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

For questions about a claim payment, contact [BEST Life's Customer Service at [1-800-433-0088 or at [cs@bestlife.com](mailto:cs@bestlife.com), Monday through Friday, 7 am to 5 pm Pacific Time].

**CLAIMS DENIAL PROCEDURE:** Any denial of a claim for Benefits will be explained in writing. The explanation will include (a) the specific reason for the denial, (b) reference to the plan provision upon which the denial was based, (c) a description of any additional information that might be required to provide and an explanation of why it is needed, and (d) an explanation of the plan's claim review procedure.

**APPEALING THE DENIAL OF A CLAIM:** You or an authorized representative You appoint to assist or represent You, may appeal any denial of a claim, in whole or in part, for Benefits by filing a written request for a review. The request must include all reasons You believe the initial decision was incorrect and all documentation supporting Your appeal, to [BEST Life and Health Insurance Company, Attn: Appeals, P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

A request for a review must be filed within one-hundred and eighty (180) days after the date on which we issue the written notice of denial of a claim. BEST Life and Health Insurance Company will provide an appeal determination not later than sixty (60) days after receipt of a request for review. If there are

special circumstances, the decision will be made as soon as possible, but no later than fifteen (15) days after receipt of the request for review. The appeal determination will be in writing and will include specific reasons for the decision. This decision shall also include specific references to the Policy provisions on which the decision was based.

## [ENDORSEMENT - SUPPLEMENTAL FAMILY DENTAL INSURANCE]

If the Policyholder selected Family Dental Coverage, then this Endorsement modifies, supplements, and becomes a part of the Policy. It provides coverage to the enrolled Eligible Persons who are at least 19 years of age until they reach the maximum eligibility age. Except as expressly provided in this Endorsement, all terms and conditions of the Certificate remain unchanged and in full force and effect.

### **Dental Plan Schedule of Benefits** **For Eligible Persons who are at least 19 years of age** **until they reach maximum eligibility age**

	[BESTOne Dental] [Advantage][Plus][Basic] Supplemental Plan	
Benefits Description	In-Network [Network]	Out-of-Network
Annual Maximum	\$[1,000 – 1,500]	
Annual Deductible	\$50	
Basic Services Coinsurance	100%	100%
Intermediate Services Coinsurance	[90-50]%	[90-50]%
Major Services Coinsurance	[60-0]%	[60-0]%

### **COVERED SERVICES ON SUPPLEMENTAL DENTAL PLAN**

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Policy.

#### **CLASS A – Basic Services:**

- (1) Routine oral examination and diagnosis not more often than twice every twelve (12) months per individual;
- (2) Bitewing x-rays not more often than once every twelve (12) months per individual;
- (3) Full mouth x-rays or panoramic films are limited to once every five (5) years; any combination of eight (8) or more x-rays (including but not limited to bitewings or periapicals/intraorals) will be combined into a full mouth x-ray series;
- (4) Prophylaxis not more often than once every six (6) months per individual.

#### **CLASS B – Intermediate Services:**

- (1) Pathology;
- (2) All fillings other than lab fabricated restorations (composite fillings limited to permanent anterior and posterior teeth);
- (3) Emergency palliative treatment;
- (4) Limited oral exam not more than once every six months;
- (5) Simple extraction, excluding orthodontic extractions unless a orthodontic benefits are a Covered Dental Expense on this Plan;



- (6) Surgical extraction, including impaction:
  - (a) erupted tooth;
  - (b) soft tissue impaction;
  - (c) partial bony impaction;
  - (d) complete bony impaction;
- (7) General anesthesia or intravenous sedation when required for complex oral surgical procedures (partial and complete bony impacted extractions only);
- (8) Periodontics (tissues and gums);
- (9) Periodontal exam (not in addition to a routine oral exam);
- (10) Periodontal maintenance (limited to once every six (6) months per individual following active periodontal treatment) and not on the same visit as a routine prophylaxis;
- (11) Periodontal scaling and root planing (limited to once every 36 months and to two (2) quadrants per visit, and not in addition to a routine prophylaxis);
- (12) Endodontics (pulp capping and root canal); and
- (13) Oral surgery:
  - (a) root recovery (surgical removal of residual root);
  - (b) oral antral fistula closure;
  - (c) removal of a dentigerous or odontogenic cyst;
  - (d) incision and drainage of an abscess;
  - (e) removal of lateral exostosis;
  - (f) frenulectomy.

**CLASS C - Major Services:**

- (1) Inlays, onlays, crowns and other lab fabricated restorations (not including veneers);
- (2) Porcelain, porcelain fused to metal, or full gold crowns on permanent teeth;
- (3) Full or partial dentures or fixed bridgework or adding teeth to an existing denture, if required because of loss of functional natural teeth while the person is covered for this Benefit. The work must be done within twelve (12) months after the extraction and while this coverage is in force;
- (4) Replacement or alteration of full or partial dentures or fixed bridgework caused by the following while coverage is in force:
  - (a) accidental injury requiring oral surgical treatment, or
  - (b) oral surgical treatment involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus or redundant tissue, provided the replacement or alteration is done within twelve (12) months of the injury or surgical treatment.
- (5) Replacement of a full denture or bridgework if the replacement is made more than seven (7) years after the date of installation, unless:
  - (a) such replacement is made necessary by the initial extraction of an adjoining functional natural tooth; or
  - (b) the prosthesis, while in the oral cavity, has been damaged beyond repair as a result of a non-chewing injury while covered;
- (6) Repair or relines of dentures and bridgework[;]
- (7) Implants, as an alternative to a fixed prosthetic, (limited to once in a lifetime per site). The cost of the fixed prosthetic will be applied to the total value of the implant and implant-related procedures, not to exceed the cost of the fixed prosthetic:
  - (a) the surgical placement of endosteal implant body including healing cap, where the bone and soft tissues are sound and healthy;
  - (b) implant supported prosthetics;
  - (c) eposteal and transosteal implants will be covered at the cost of the endosteal implant (if performed, member is responsible for additional fees);
  - (d) bone grafting and tooth extractions, provided the work is done while this coverage is in force;
  - (e) implant maintenance[.].

## EXCLUSIONS ON SUPPLEMENTAL DENTAL PLAN

The following exclusions are not Covered Services. No payments will be made by Us for these services:

- (1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a dentist;
- (2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
- (3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
- (4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;
- (5) Services and supplies begun and not completed prior to the patient's effective date, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
- (6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
- (7) Pulp capping, if in conjunction with the installation of inlays, onlays or crowns and fillings or other lab fabricated restorations; including but not limited to inlays, onlays and crowns, preventative tests and examinations diagnostic casts and oral cancer screenings, and expenses incurred for sedative fillings, including charges for prescribed drugs, pre-medication or analgesia;
- (8) The initial installation of a prosthetic device (a fixed bridge, implant, or denture), including crowns and inlays which form abutments, to replace teeth missing before You were covered under the Policy, except when it also replaces a tooth that is extracted while covered unless such installation commences after You have remained continuously covered under this plan for at least three years immediately prior to the date such installation commences;
- (9) Implants, implant services and implant supported prosthetics;
- (10) Expenses incurred for veneers and related procedures;
- (11) Replacement of a lost or stolen or discarded prosthetic device;
- (12) Adjustment, repairs or relines of prostheses for a period of one (1) year from initial placement if the prostheses were paid for under this plan;
- (13) Expenses incurred for a core buildup will only be considered in conjunction with a crown;
- (14) If multiple endodontic treatments are necessary on the same tooth within a period of one (1) year, the allowance will be made for only one (1) procedure;
- (15) X-rays are considered an integral part of the endodontic procedure rather than a separate service and are therefore not eligible for benefits;
- (16) The extraction of immature erupting third molars and non-pathologic, asymptomatic third molar extractions;
- (17) Expenses for gross debridement allowed one time at the beginning of the periodontal treatment plan prior to pocket depth charting;
- (18) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
- (19) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are a Covered Dental Expense on this Plan;

- (20) Surgical procedures incidental to orthodontic treatment, including but not limited to, extraction of teeth solely for orthodontic reasons, exposure of impacted teeth, correction of micrognathia or macrognathia, or repair of cleft palate;
- (21) Charges for service provided for temporomandibular joint dysfunction (TMJ);
- (22) Expenses incurred for congenital or developmental malformations;
- (23) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
- (24) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits;
- (25) Chemotherapeutic agents and any other experimental procedures;
- (26) Charges in excess of the In-Network Provider Fee Schedule for the services in the area where treatment was received or charges in excess of the Calendar Year Maximum amount stated in the "Schedule of Dental Benefits" section of this Plan;
- (27) Expenses that are applied toward satisfaction of a Deductible, if any;
- (28) Services and supplies performed outside of the United States of America;
- (29) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, Your lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;
- (30) Expenses for services for which You would not legally have to pay if there were no insurance;
- (31) Services not completed on or before the date of termination;
- (32) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
- (33) Any service or procedure not commonly found within the scope of practice by a licensed dentist. Such procedures are identified within the current Common Dental Terminology (CDT Codes) published by the American Dental Association;
- (34) Expenses incurred for services covered on a pediatric only dental plan.]

**Underwritten by BEST Life and Health Insurance Company**

# ~~Individual Insurance Policy~~

## ~~Dental PPO Plan~~



~~{2505 McCabe Way  
Irvine, California 92614}~~

~~Notice to Buyer: This Policy provides dental  
coverage only.~~

---

~~IFD-PPO-POL-0113TN~~

**BEST Life and Health Insurance Company**  
[2505 McCabe Way  
Irvine, California 92614]

A STOCK COMPANY  
(Herein called the Company)

**BEST Life and Health Insurance Company ("BEST Life")** is issuing this Policy in consideration of the accuracy of representations made in Your application and Your payment of premiums for Policy coverage.



**READ YOUR POLICY CAREFULLY:** This Policy is a legal contract between You (owner of this Policy) and Us.

**GOVERNING JURISDICTION:** The Policy is issued in the State of Tennessee. It shall be construed in accordance with the laws of the issuing State.

**NOTICE OF TEN DAY RIGHT TO EXAMINE:** We want You to fully understand and be satisfied with the insurance coverage.— If for any reason You are not satisfied, You may return this Policy to Your agent or to Our home office within ten (10) days of receipt and Your premium will be fully refunded. Coverage will then be void retroactive to the Insurance Effective Date.

**RENEWAL AND PREMIUM PAYMENT PROVISIONS:** You may renew this Policy for additional coverage periods by paying the premium when due or within the Grace Period until the Insureds reach the maximum eligibility ageage [19][65].— Each period of coverage runs from premium due date to premium due date.— We reserve the right to change premiums.— Any such change will be made according to the table of premium rates that will apply to all policies with the same form and class in Your State.— All future renewal premiums will be based on Your original issue age.— We will notify You of any premium rate increase at least sixty (60) days in advance.— We cannot cancel this Policy while it is in force.

**IN WITNESS WHEREOF,** We have caused this Policy to be signed by Our President and Our Secretary. This Policy takes effect at 12:01 a.m. at Your residence on its Effective Date.— This Policy terminates at 12:01 a.m. on the date any renewal premium is due and not paid, subject to the Grace Period.

[-----]  ----- [-----]  ----- ]

President-----Secretary

**Dental PPO Insurance Policy**

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This Policy Is Not Valid  
Unless There Is a Complete Statement of Coverage

Statement of Coverage

DENTAL

INSURANCE ~~SUBSCRIBER~~POLICYHOLDER NAME: [JOHN D. DOE]  
POLICY EFFECTIVE DATE: [01/01/2014]

INSURED NAME(S) AND EFFECTIVE DATE(S):

[JANE DOE 01/01/2014]

[JON DOE 01/01/2014]

[PLAN: [PPO HIGH]

DEDUCTIBLE: [\$50]

ANNUAL MAXIMUM: [\$1,000]

PEDIATRIC DENTAL PLAN: [PPO HIGH]

DEDUCTIBLE: [\$50]

OUT OF POCKET MAXIMUM: [\$700]

POLICY NO.: [XXXXXXXXXX]

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## PART 1 - SCHEDULE OF BENEFITS

This Policy is made valid on the effective dates shown for the listed Insureds on the Statement of Coverage.

Covered Services received by Insured from a Network Provider are reimbursed at the Network Provider's contracted Fee Schedule. Covered Services received by Insured from an Out-of-Network Provider are reimbursed at the at the In-Network Provider Fee Scheduled amount for the Covered Services in the area where delivered. ~~[80th or 90th] percentile of a Usual, Reasonable and Customary schedule.~~ All Covered Services are subject to Cost Sharing as shown on this Schedule of Benefits.

### [Pediatric Dental Plan Schedule of Benefits For Children to Age 19]

Procedure Categories	[BEST Life Child Dental] [Plus] Pediatric Dental Plan	
	In-Network [Network Name]	Out-of-Network
<b>Out-of-Pocket Maximum</b>	\$700 for 1 Child \$1,400 for 2 or more Children	\$700 for 1 Child \$1,400 for 2 or more Children
<b>Annual Deductible</b> – Applies to [Preventive], [services received Out-of-Network as well as] Basic and Major services received In-Network or Out-of-Network	\$[0][2050]	\$[50][2400]
<del>Diagnostic &amp; Preventive Services</del> <b>Basic Services Coinsurance</b> – Exams, cleanings, sealants, fluoride	100%	[90][60]%
<del>Intermediate</del> <b>Basic Services Coinsurance</b> – Fillings	[70][55]%	[60][40]%
<b>Major Services Coinsurance</b> – Crowns & casts, prosthodontics, endodontics, periodontics, oral surgery	[50][35]%	[40][20]%
<b>Medically Necessary Orthodontic Services Coinsurance</b> <del>(Medically necessary Orthodontic Services only)</del>	50% [24 Month Wait]	50% [24 Month Wait]

**~~{Dental Plan Schedule of Benefits  
For Adults and Dependent Children between 19 and 26}~~**

	<del>{BESTOne Dental} {Advantage} {Plus} {Basic} Supplemental Plan</del>	
<b>Benefits Description</b>	<b>In-Network {Network}</b>	<b>Out-of-Network</b>
<del>Annual Maximum</del>	<del>[\$500—3,500]</del>	
<del>Annual Deductible (Applies to Basic and Major) — 3 Deductible- Maximum per Family</del>	<del>[\$0-100]</del>	
<del>Preventive Care Services Routine oral exam, cleanings, X-rays</del>	<del>{100-70}%</del>	<del>{100-70}%</del>
<del>Basic Services Fillings (amalgam, porcelain &amp; plastic), anterior &amp; posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology</del>	<del>{90-50}%</del>	<del>{80-20}%</del>
<del>Major Services Crowns &amp; gold fillings, inlays, onlays &amp; pontics, [implants,] fixed bridges, complete &amp; partial dentures</del>	<del>{60-0}%</del>	<del>{50-0}%</del>
<del>{Major Services Waiting Period}</del>	<del>12 Months</del>	
<del>Endodontic Services</del>	<del>{Basic} {Major}</del>	
<del>Periodontic Services</del>	<del>{Basic} {Major}</del>	
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<b>Usual and Customary Reimbursement</b>	<b>Fee Schedule</b>	<b>{80<sup>th</sup>} {90<sup>th</sup>} Percentile</b>

}

**PART 2 - BENEFITS AND EXCLUSIONS**

**COVERED SERVICES ON  
PEDIATRIC DENTAL PLAN**

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Policy.

**Class I – Preventive and Diagnostic Procedures Include:**

- (1) Prophylaxis not more often than once every six (6) months;
- (2) Topical application of fluoride (excluding prophylaxis) not more often than twice every twelve (12) months;
- (3) Topical fluoride varnish not more often than twice every twelve (12) months;
- (4) Sealants not more often than once per tooth in a thirty-six (36) month period and limited to unrestored permanent molars for individuals under age nineteen (19);
- (5) Space maintainers, including re-cementation, ~~—~~ for individuals under age nineteen (19) (excluding removal of fixed space maintainer);
- (6) Periodic oral evaluation not more often than once every six (6) months;
- (7) Limited oral evaluation (problem focused) not more often than once every six (6) months;
- (8) Comprehensive oral evaluation not more often than once every six (6) months;
- (9) Comprehensive periodontal evaluation not more often than once every six (6) months;
- (10) Intraoral complete X-rays or panoramic film not more often than once in a 60-month period;
- (11) Bitewing X-rays not more often than one set every six (6) months;
- (12) Single film intraoral periapical or occlusal;

- (13) Palliative treatment of dental pain (minor procedure);

**Class II – Basic Procedures Include:**

- (1) Amalgams, resin-based composites, re-cement inlays, re-cement crowns, protective restoration, pin retention;
- (2) Prefabricated stainless steel crowns not more often than once per tooth in a sixty (60) month period for individuals under age fifteen (15);
- (3) Therapeutic pulpotomy (excluding restoration) if a root canal is not performed within forty-five (45) days of the pulpotomy;
- (4) Partial pulpotomy for apexogenesis limited to permanent tooth with incomplete root development, if a root canal is not performed within forty-five (45) days of pulpotomy;
- (5) Pulpal therapy (excluding final restoration) once per tooth per lifetime, limited to primary incisor teeth for individuals up to age six (6), and limited to primary molars and cuspids for individuals up to age eleven (11);
- (6) Periodontal scaling and root planning, per quadrant, not more often than once every twenty-four (24) months;
- (7) Periodontal maintenance not more often than four in a twelve (12)-month period, combined with adult prophylaxis after the completion of active periodontal therapy;
- (8) Adjustment and repair of complete or partial dentures;
- (9) Rebase and reline not more often than once in a thirty-six (36) month period, six (6) months after initial installation;
- (10) Tissue conditioning;
- (11) Recement fixed partial denture
- (12) Fixed partial denture repair, by report;
- (13) Oral surgery:
  - a. extraction for erupted tooth or exposed root;
  - b. surgical removal of erupted tooth;
  - c. removal of impacted tooth;
  - d. removal of residual tooth roots;
  - e. coronectomy;
  - f. tooth reimplantation;
  - g. surgical access of unerupted tooth;
  - h. alveoloplasty;
  - i. removal of exostosis;
  - j. incision and drainage of abscess;
  - k. suture of recent small wounds up to five (5) cm
  - l. excision of pericoronal gingival;

**Class III – Major Procedures Include:**

- (1) Detailed and extensive oral evaluation;
- (2) Inlays, onlays, crowns, core buildup, including any pins, prefabricated post and core in addition to crown, limited to one per tooth every sixty (60) months;
- (3) Endodontics (root canal)
- (4) Gingivectomy or gingivoplasty, four (4) or more teeth not more often than once every thirty-six (36) months;
- (5) Gingival flap procedure, four (4) or more teeth not more often than once every thirty-six (36) months;
- (6) Osseous surgery, four (4) or more contiguous teeth or bounded teeth spaces per quadrant, not more often than once every thirty-six (36) months;
- (7) Full mouth debridement limited to one (1) ~~per~~ lifetime;

- (8) Complete and partial dentures, including abutments, pontics, onlays, retainers and crowns, ~~—~~ not more often than once every sixty (60) months (excludes interim dentures);
- (9) Implants and implant services once every sixty (60) months only if medically necessary;
- (10) Occlusal guard not more often than once in twelve (12) months for individuals thirteen (13) and older with predetermination only;
- (11) General anesthesia or IV sedation;
- (12) Consultation by dentist or physician other than the dentist providing treatment;
- (13) Therapeutic drug injection with predetermination;
- (14) Treatment of post-surgical complications with predetermination.

[**Note:** Unless the twenty-four (24) month waiting period requirement for Medically Necessary Orthodontic services has been met, the services below are not covered benefits for any treatment that began during the twenty-four (24) month period immediately following Your effective date of coverage.]

**Class IV – Medically Necessary Orthodontic Procedures Include:**

- (1) For orthodontia services associated with the repair of cleft palate and palate or other severe craniofacial defects or injury for which the function of speech, swallowing or chewing is restored;
- (2) Requires predetermination; and
- (3) Coverage includes diagnosis, treatment plan, anticipated treatment time and cost estimate.

**EXCLUSIONS ON  
PEDIATRIC DENTAL PLAN**

The following exclusions are not Covered Services. No payments will be made by Us for these services:

- (1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;
- (2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
- (3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
- (4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;
- (5) Services and supplies started and not completed before the patient was covered under this Plan, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
- (6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
- (7) Space maintainers;
- (8) Sealants if re-sealed within a five (5) year period;
- (9) Retreatment of a previous root canal or apicoectomy/periradicular surgery;
- (10) Elective tooth extractions;
- (11) Separate payments for open and drain palliative procedure when the root canal is completed on the same date of service;
- (12) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are defined as a Covered Dental Expense;
- (13) Charges in excess of Usual, Reasonable and Customary charges amount stated in the "Schedule

- of Benefits” section of this Plan, or in excess of the Preferred Provider Fee Schedule;
- (14) Charges for service provided for temporomandibular joint dysfunction (TMJ);
  - (15) Expenses incurred for congenital or developmental malformations, except as defined as a Covered Orthodontic Expense;
  - (16) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits, except as defined as a Covered Orthodontic Expense;
  - (17) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
  - (18) Expenses incurred due to treatment rendered by a family member.—For the purpose of this limitation, "family member" includes, but is not limited to, the patient's lawful spouse, domestic partner,—child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;
  - (19) Expenses for services for which the patient would not legally have to pay if there were no insurance, unless mandated by the State;
  - (20) Services not completed on or before the date of termination;
  - (21) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
  - (22) Expenses that are applied toward satisfaction of a Deductible, if any;
  - (23) Any service or procedure not commonly found within the scope of practice by a licensed dentist;
  - (24) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
  - (25) Chemotherapeutic agents and any other experimental procedures;
  - (26) Expenses incurred for veneers and related procedures;
  - (27) Services and supplies performed outside of the United States of America.

### ~~COVERED SERVICES ON SUPPLEMENTAL DENTAL PLAN~~

~~Covered Services are those services described below, unless they are limited or excluded elsewhere in this Policy.~~

#### ~~CLASS I – Preventive Dental Procedures include:~~

- ~~— Routine oral examination and diagnosis not more often than twice every twelve (12) months per individual;~~
- ~~— Bitewing x-rays not more often than once every twelve (12) months per individual;~~
- ~~— Full mouth x-rays or panoramic films are limited to once every five (5) years; any combination of eight (8) or more x-rays (including but not limited to bitewings or periapicals/intraorals) will be combined into a full mouth x-ray series;~~
- ~~— Prophylaxis not more often than once every six (6) months per individual.~~

#### ~~CLASS II – Basic Dental Procedures include:~~

- ~~(1) Pathology;~~
- ~~(2) All fillings other than lab fabricated restorations (composite fillings limited to permanent anterior and posterior teeth);~~
- ~~(3) Emergency palliative treatment;~~
- ~~(4) Limited oral exam not more than once every six months;~~
- ~~(5) Simple extraction, excluding orthodontic extractions unless a orthodontic benefits are a Covered Dental Expense on this Plan;~~

- ~~(6) Surgical extraction, including impaction:
  - erupted tooth;
  - soft tissue impaction;
  - partial bony impaction;
  - complete bony impaction;~~
- ~~(7) General anesthesia or intravenous sedation when required for complex oral surgical procedures (partial and complete bony impacted extractions only);~~
- ~~(8) Periodontics (tissues and gums);~~
- ~~(9) Periodontal exam (not in addition to a routine oral exam);~~
- ~~(10) Periodontal maintenance (limited to once every six (6) months per individual following active periodontal treatment) and not on the same visit as a routine prophylaxis;~~
- ~~(11) Periodontal scaling and root planing (limited to once every 36 months and to two (2) quadrants per visit, and not in addition to a routine prophylaxis);~~
- ~~(12) Endodontics (pulp capping and root canal); and~~
- ~~(13) Oral surgery:
  - root recovery (surgical removal of residual root);
  - oral antral fistula closure;
  - removal of a dentigerous or odontogenic cyst;
  - incision and drainage of an abscess;
  - removal of lateral exostosis;
  - frenulectomy.~~

[**Note:** Unless the twelve (12) month waiting period requirement for Major Dentistry services has been met, the services below are not covered benefits for any treatment that began during the twelve (12) month period immediately following Your effective date of coverage.]

**CLASS III – Major Dental Procedures include:**

- ~~(1) Inlays, onlays, crowns and other lab fabricated restorations (not including veneers);~~
- ~~(2) Porcelain, porcelain fused to metal, or full gold crowns on permanent teeth;~~
- ~~(3) Full or partial dentures or fixed bridgework or adding teeth to an existing denture, if required because of loss of functional natural teeth while the person is covered for this Benefit. The work must be done within twelve (12) months after the extraction and while this coverage is in force;~~
- ~~(4) Replacement or alteration of full or partial dentures or fixed bridgework caused by the following while coverage is in force:
  - (a) accidental injury requiring oral surgical treatment; or
  - (b) oral surgical treatment involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus or redundant tissue, provided the replacement or alteration is done within twelve (12) months of the injury or surgical treatment.~~
- ~~(5) Replacement of a full denture or bridgework if the replacement is made more than seven (7) years after the date of installation, unless:
  - such replacement is made necessary by the initial extraction of an adjoining functional natural tooth; or
  - the prosthesis, while in the oral cavity, has been damaged beyond repair as a result of a non-chewing injury while covered;~~
- ~~(6) Repair or reline of dentures and bridgework;~~
- ~~(7) Implants, as an alternative to a fixed prosthetic, (limited to once in a lifetime per site). The cost of the fixed prosthetic will be applied to the total value of the implant and implant related procedures, not to exceed the cost of the fixed prosthetic:
  - (1) the surgical placement of endosteal implant body including healing cap, where the bone and soft tissues are sound and healthy;
  - (2) implant supported prosthetics;~~

- ~~(3) eposteal and transosteal implants will be covered at the cost of the endosteal implant (if performed, member is responsible for additional fees);~~
- ~~(4) bone grafting and tooth extractions, provided the work is done while this coverage is in force;~~
- ~~(5) implant maintenance].~~

### **EXCLUSIONS ON SUPPLEMENTAL DENTAL PLAN**

The following exclusions are not Covered Services. No payments will be made by Us for these services:

- ~~-~~
- ~~— Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;~~
- ~~— Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;~~
- ~~— Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;~~
- ~~— Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;~~
- ~~— Services and supplies begun and not completed prior to the patient's effective date, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;~~
- ~~— Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;~~
- ~~— Pulp capping, if in conjunction with the installation of inlays, onlays or crowns and fillings or other lab fabricated restorations; including but not limited to inlays, onlays and crowns, preventative tests and examinations diagnostic casts and oral cancer screenings, and expenses incurred for sedative fillings, including charges for prescribed drugs, pre-medication or analgesia;~~
- ~~— The initial installation of a prosthetic device (a fixed bridge, implant, or denture), including crowns and inlays which form abutments, to replace teeth missing before You were covered under the Policy, except when it also replaces a tooth that is extracted while covered unless such installation commences after You have remained continuously covered under this plan for at least three years immediately prior to the date such installation commences;~~
- ~~— Implants, implant services and implant supported prosthetics[ are not covered for patients under the age of sixteen (16)];~~
- ~~— Expenses incurred for veneers and related procedures;~~
- ~~— Replacement of a lost or stolen or discarded prosthetic device;~~
- ~~— Adjustment, repairs or relines of prostheses for a period of one (1) year from initial placement if the prostheses were paid for under this plan;~~
- ~~— Expenses incurred for a core buildup will only be considered in conjunction with a crown;~~
- ~~— If multiple endodontic treatments are necessary on the same tooth within a period of one (1) year, the allowance will be made for only one (1) procedure;~~
- ~~— X rays are considered an integral part of the endodontic procedure rather than a separate service and are therefore not eligible for benefits;~~
- ~~— The extraction of immature erupting third molars and non pathologic, asymptomatic third molar extractions;~~
- ~~— Expenses for gross debridement allowed one time at the beginning of the periodontal treatment plan prior to pocket depth charting;~~
- ~~— Temporary services are considered an integral part of the final services rather than a separate~~

- ~~service and are therefore not eligible for benefits;~~
- ~~— Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are a Covered Dental Expense on this Plan;~~
- ~~— Surgical procedures incidental to orthodontic treatment, including but not limited to, extraction of teeth solely for orthodontic reasons, exposure of impacted teeth, correction of micrognathia or macrognathia, or repair of cleft palate;~~
- ~~— Charges for service provided for temporomandibular joint dysfunction (TMJ);~~
- ~~— Expenses incurred for congenital or developmental malformations;~~
- ~~— Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);~~
- ~~— Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits;~~
- ~~— Chemotherapeutic agents and any other experimental procedures;~~
- ~~— Charges in excess of Usual, Reasonable and Customary charges or in excess of the Calendar Year Maximum amount stated in the "Schedule of Dental Benefits" section of this Plan, or in excess of the Preferred Provider Fee Schedule;~~
- ~~— Expenses that are applied toward satisfaction of a Deductible, if any;~~
- ~~— Services and supplies performed outside of the United States of America;~~
- ~~— Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, Your lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;~~
- ~~— Expenses for services for which You would not legally have to pay if there were no insurance;~~
- ~~— Services not completed on or before the date of termination;~~
- ~~— If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;~~
- ~~— Any service or procedure not commonly found within the scope of practice by a licensed dentist. Such procedures are identified within the current Common Dental Terminology (CDT Codes) published by the American Dental Association;~~
- ~~— Expenses incurred for services covered on a pediatric only dental plan.]~~

## **PART 3 - LIMITATIONS AND COST SHARING**

### **ACCESS TO CARE**

#### **Using a Network Provider:**

BEST Life offers Insureds the option to save on out-of-pocket costs when care is provided by a Network Provider. A listing of General Dentists and Specialists is available. To find a Network Provider, please refer to the Network information provided on the ID Card.

#### **How to Select a Dentist:**

Insureds on this Plan may obtain dental services from any licensed dental professional in the United States. To use the Plan, Insureds may directly contact the dentist of their choice and make an appointment. Insureds are advised to bring their ID Card to their appointment. ~~— The dentist may require a copy of the Insured's ID Card to confirm eligibility on this Plan.~~

#### **How to Obtain a Referral:**

A dentist may determine that an Insured requires treatment from a dental provider that specializes in a type of dentistry (Specialist). ~~— The Insured does not need to contact BEST Life for a referral. The Insured can directly contact the Specialist to make an appointment. The Specialist may require information from the Insured's dentist to determine a treatment plan and may contact the dentist directly.~~



## ADVANCE NOTICE OF DENTAL TREATMENT

SubscriberPolicyholder or Insured should submit Advance Notice of Dental Treatment before treatment commences in order to obtain Predetermination of Covered Services, including services that are medically necessary. If dental services are performed without such Predetermination, We reserve the right to deny any claim submitted with respect to such Covered Services; provided however, that predetermination is not required for:

- (1) Covered Services for which the related expense is less than \$500 during any course of treatment ("course of treatment" means one treatment or one of a planned series of treatments resulting from dental examination);
- (2) Emergency treatment; or
- (3) Oral examination and prophylaxis.

Predetermination is required for the following dental services for children:

- (1) Medically necessary services or supplies;
- (2) Panoramic film for children under age six (6);
- (3) Periodontal scaling and root planing;
- (4) Occlusal orthotic devices;
- (5) Appliance therapy;
- (6) Orthodontia, including preorthodontic treatment visit.

Predetermination is required for the following dental services for adults and children 19 or older:

- (1) Crowns, Anterior, except with posts or root canal;
- (2) Crowns, 2 or more Posterior, except with posts or root canal;
- (3) Inlays or Onlays, 2 or more, except with posts or root canal;
- (4) Laminates;
- (5) Anterior composites;
- (6) 2 or more multiple surfaces;
- (7) Bridges – initial or replacement;
- (8) Eligible partial dentures – initial or replacement;
- (9) Periodontal surgery over \$500;
- (10) Full bony impactions, 2 or more.

We will have thirty (30) days to furnish the provider with an Explanation of Benefits demonstrating whether the proposed treatment will be a Covered Service under this Policy.

## DEDUCTIBLES

**Annual Deductible:** The Annual Deductible shown in the Schedule of Dental Benefits will apply separately to each Insured. Each Insured must accumulate eligible expenses equal to the deductible amount.

## ALTERNATIVE PROCEDURES

If more than one treatment plan exists for a dental procedure, covered dental expenses will be based on the least expensive procedure that will produce a result that meets professionally recognized standards. If the Insured's provider elects the more expensive treatment, the Insured or SubscriberPolicyholder

shall be responsible for any charges that are greater than the covered expense for the less expensive treatment.

#### **PART 4 - DEFINITIONS**

**Annual:** The twelve (12) month period beginning on the effective date of the Certificate and ending on the termination date of the Certificate. The Annual time frame will be applied to the Deductible and the Annual Maximum amount.

**Annual Deductible:** The amount each Insured must satisfy before Benefits are payable by Us. To satisfy the Annual Deductible, the Insured must accumulate expenses for Covered Services equal to the Deductible amount shown on the Schedule of Benefits.

**Annual Maximum:** The maximum amount BEST Life will reimburse for covered services during a twelve (12) month period for each Insured person.—Once the full Annual Maximum amount has been paid, no additional services will be reimbursed for the remainder of that year. The

**Child:** A dependent child who meets the definition of Eligible Person may be enrolled and covered under this Policy, as follows:

1. A child who is less than nineteen (19) years of age on the coverage effective date will be covered on the Pediatric Dental Plan until that child is nineteen (19) years of age on the renewal date;
2. A child who is older than nineteen (19) years of age on the coverage effective date or renewal date may be covered under the Supplemental Family Dental Insurance, if Supplemental Family Dental Insurance is endorsed onto the policy.

~~**Child:** A person under the age of twenty-six (26) years. Depending on the Child's age, an enrolled Child may be covered either on the Pediatric Dental Plan or Supplemental Dental Plan as follows:~~

- ~~—A Child who is less than nineteen (19) years of age on the coverage effective date will be covered on the Pediatric Dental Plan until that Child is nineteen (19) years of age on the renewal date;~~
- ~~—A Child who is between nineteen (19) and twenty-six (26) years of age on the coverage effective date will be covered on the Supplemental Dental Plan until that Child no longer meets the definition of an Eligible Dependent.~~

**Coinsurance:** The amount of an expense for a Covered Service that we will pay once the deductible is satisfied.

**Covered Dependent:** A Child who is an Eligible Person and who is enrolled in and covered under an active policy of insurance issued to the Policyholder named on the Statement of Coverage.

**Covered Service:**—A service or supply listed as a Covered Service and not otherwise limited or excluded by this Certificate. A Covered Service must be provided by a doctor of medical dentistry or a doctor of dental surgery, or a denturist.

**Eligible Person:**

- (1) You [to age 65]
- (2) Your lawful spouse or domestic partner [to age 65]; and
- (3) Your or Your spouse's or domestic partner's child or children, including a natural child, step-child, foster child, lawfully adopted child or child in the process of being adopted, from the date of placement, or any child for whom You have been granted legal custody, provided they are less than twenty-six (26) years of age; or

(4) A child named in a Qualified Medical Child Support Order will be considered an Eligible Person.

“Eligible Person” also means a dependent child, who upon reaching the termination age, is unable to sustain employment because of a permanent mental or physical handicap and You notify Us in writing within thirty-one (31) days after the termination age, the child will continue to qualify as a dependent under this plan, provided You and the dependent child continue to be insured under this plan, and the child continues to be handicapped and dependent upon You for support. This shall not apply to a dependent child who is beyond the termination age on the date You become eligible for dependent insurance under this Policy.

Eligible Dependent: Means:

- (1) Your lawful spouse or domestic partner and
- (2) Your or Your spouse's or domestic partner's child or children, including a natural child, step child, foster child, lawfully adopted child or child in the process of being adopted, from the date of placement, or any child for whom You have been granted legal custody, provided they are [less than][between 20 and] 26 years of age; or
- (3) A child named in a Qualified Medical Child Support Order will be considered a dependent.

“Eligible Dependent” also means a dependent child, who upon reaching the termination age, is unable to sustain employment because of a permanent mental or physical handicap and You notify Us in writing within thirty one (31) days after the termination age, the child will continue to qualify as a dependent under this plan, provided You and the dependent child continue to be insured under this plan, and the child continues to be handicapped and dependent upon You for support. This shall not apply to a dependent child who is beyond the termination age on the date You become eligible for dependent insurance under this Policy.

**Family Deductible:** The Family Deductible is satisfied when each of three (3) covered members of Your family satisfy the Annual Deductible.—Once the combined costs of services provided by covered members of Your family is equal to the Family Deductible amount, no additional Deductible will be required for other insured family members for the remainder of the Calendar Year.

**Emergency Care:** A dental emergency where an acute disorder of oral health requires dental and/or medical attention, including broken, loose, or evulsed teeth caused by traumas; infections and inflammations of the soft tissues of the mouth; and complications of oral surgery, such as dry tooth socket.

**Grace Period:** A Grace Period of thirty-one (31) days from the due date will be allowed for payment of each premium after the first. This coverage will remain in effect during the Grace Period; provided the premium is paid before the end of the Grace Period.

**Insured:**—The SubscriberPolicyholder or any Eligible Dependent of a SubscriberPolicyholder who is enrolled in and covered under the Policy.

**Medically Necessary:** The determination process that may include, and not limited to, the evaluation of the effectiveness and benefit of a dental service or supply for the individual patient based on scientific evidence considerations, up-to-date and consistent professional standards of care, convincing expert opinion and a comparison to alternative interventions, including interventions, and the cost effectiveness of such service or supply. Medical necessity may be obtained by applying an Advance Notice of Treatment.

**Network Provider:** A dental care professional that is contracted with Us and is part of the Network shown on the Schedule of Benefits.

**Out-of-Pocket Maximum:** The total amount of expenses related to Covered Services, in addition to the Deductible, that must be paid on behalf of an Insured on an Annual basis.

**Out-of-Network Provider:** A dental care professional that is not a Network Provider.

**Policy Effective Date:** The date shown on the Statement of Coverage as the Policy Effective Date.

**Statement of Coverage:** The proof of insurance issued to an individual insured under the Policy, outlining the insurance benefits and principle provisions applicable to the member.

**~~Subscriber:~~** ~~The primary insured person as shown on the Statement of Coverage.~~

**Usual, Reasonable and Customary:** The charge for health care that is consistent with the average rate or charge for identical or similar services in a certain geographical area.

**You or Your:** Means the ~~Insured~~ Policyholder.

## **PART 5—COVERAGE EFFECTIVE AND TERMINATION DATES**

### **PART 5 – ENROLLMENT, EFFECTIVE DATE AND TERMINATION DATE**

#### **ENROLLMENT**

A person eligible as a Policyholder must:

- (1) Enroll all Eligible Persons in accordance with the annual open enrollment period;
- (2) Enroll all Eligible Persons within thirty (30) days of one of the following triggering events:
  - (a) The date on which an Eligible Person loses minimum essential coverage;
  - (b) A Policyholder gains an Eligible Person Child;
  - (c) A person becomes an Eligible Person through marriage, birth, adoption or placement for adoption;
  - (d) An Eligible Person's enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or HHS, or its instrumentalities as evaluated and determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;
  - (e) An enrollee adequately demonstrates to the Exchange that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
  - (f) An Eligible Person gains access to new qualified health plans as a result of a permanent move;
  - (g) An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a QHP or change from one QHP to another one time per month; and
  - (h) An Eligible Person demonstrates that the individual meets other exceptional circumstances.

#### **EFFECTIVE DATE**

Your insurance will become in effect as follows:

- (1) If enrollment is received between the first (1<sup>st</sup>) and the fifteenth (15<sup>th</sup>) day of the enrollment period, coverage will be effective on the first day of the following month; and
- (2) If enrollment is received between the sixteenth (16<sup>th</sup>) and the last day of the enrollment period, coverage will be effective on the first day of the second following month.

#### **TERMINATION DATE**

Coverage may be terminated, as follows:

- (1) You may terminate coverage with appropriate notice.
- (2) We may terminate coverage in the following circumstances:
  - (a) You are no longer eligible for coverage through the Exchange;
  - (b) Non-payment of premiums;
  - (c) Your coverage is rescinded;
  - (d) We terminate or decertify; or
  - (e) You change insurance carriers during an annual open enrollment period or special enrollment period.

#### **EFFECTIVE DATE**

~~Coverage:~~ The Insured's coverage will take effect on the Insured's Effective Date as shown on the Statement of Coverage.

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#### **TERMINATION OF INSURANCE**

The Insured's coverage will stop on the earliest of the following dates:

- ~~(1) the last day of the month in which the Subscriber stops being a member of the Association;~~
- ~~(2) the last day of the month in which the Insured stops being a member of a class eligible for insurance under this plan;~~
- ~~(3) the last day of the month in which the Subscriber requests coverage be cancelled;~~
- ~~(4) the day before the due date of any premium that remains unpaid at the end of the Grace Period;~~
- ~~(5) the date the Policy terminates;~~
- ~~(6) the last day of the month in which an Insured stops meeting the definition of Eligible Dependent; or~~
- ~~(7) the day the Insured moves outside of the service area for Insured's selected network. Insured may request a plan change if Insured moves within an area where an alternate plan is available.~~

~~BEST Life will notify Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of this insurance coverage.~~

#### **PART 6 –PREMIUM PROVISIONS**

**Premium Payments:** Renewal premiums are payable to the Company.—The payment of any premium shall not continue this Policy in force beyond the next premium due date, except as provided in the Grace Period provision.

**Changes in Premiums:** We may change the amount of the required premium due from the Policyholder by giving the Policyholder at least sixty (60) days advance written notice. During the first 12 months, We will not change the amount of the required premium.

**Grace Period:** This Policy has a thirty-one (31) day Grace Period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following thirty-one (31) days. During the Grace Period, this Policy will remain in force.—If the required premium is not paid by the end of this Grace Period, this Policy will lapse as of the last paid through date end of the Grace Period.

~~**Termination of Policy:** We may terminate this Policy at any time following the first renewal date by giving the Policyholder written notice at least sixty (60) days in advance.—The Policyholder may also terminate this Policy by giving Us written notice at least sixty (60) days before the intended termination~~

~~date. This Policy will also terminate if the required premium is not paid by the Policyholder as provided in the Grace Period provision.~~

**Reinstatement:** If any renewal premium is not paid by the end of the Grace Period, coverage under this Policy will be terminated. However, BEST Life will reinstate this Policy, without requiring an application for reinstatement, as long as premium is paid for at least the sixty (60) days prior to the date of reinstatement. The reinstated Policy will cover only loss resulting from an accidental injury sustained after the date of reinstatement and loss due to sickness beginning ten (10) days after reinstatement. In all other respects the insured and BEST Life shall have the same rights as they had under the Policy immediately before the due date of the defaulted premium, subject to conditions and provisions of the Policy.

## **PART 7 – GENERAL PROVISIONS**

**Clerical Error:** Clerical error by the Policyholder shall not invalidate insurance otherwise validly in force nor continue insurance otherwise validly terminated.

**Third Party Responsibility:** If an Insured is injured or becomes ill through the act or omission of another person, to the extent that the Insured recovers medical expenses for the same Injury or Illness from a third party or its insurer, We will be entitled to a repayment of any remuneration in excess of benefits paid under the Policy due to the same Injury or Illness, and after the Insured is fully compensated for his or her loss. We may file a lien for such repayment. Upon request, the Insured must complete and return the required forms to Us.

The repayment agreement will be binding upon the Insured, or the legal representative of a minor or incompetent, whether:

- (1) the payment received from the third party, or its insurer, is the result of:
  - legal judgment;
  - an arbitration award;
  - a compromise settlement;
  - any other arrangements; or
- (2) the third party or its insurer had admitted liability for the payment; or
- (3) the medical expenses are itemized in the third party payment.

**Entire Contract; Changes:** The Policy, including the endorsements, certificates, riders, application and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions. We will consider any statement made by the Insured or the Policyholder, in the absence of fraud, as a representation and not a warranty.

**Underwriting Decisions:** If, for any reason, We cannot accept Your application for coverage, We will communicate Our decision to You in writing with the reasons supporting Our decision.

**Notification to Insureds:** BEST Life will notify ~~Subscriber~~Policyholder in writing by mail to ~~Subscriber~~Policyholder's last known address at least thirty (30) days prior to the effective date of the termination of your insurance, a change in your premium, a change in eligibility or a change in your benefits.

**Right to Contest:** After this Policy has been in force for a period of two (2) years during the lifetime of

the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application. No claim for loss incurred or disability (as defined in the Policy) commencing after two (2) years from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Policy.

**Notice of Claim:** We must receive written notice within twenty (20) days after a claim starts or as soon as reasonably possible. The notice shall be sent to [BEST Life and Health Insurance Company at ‡2505 McCabe Way, Irvine, California 92614] or given it to Our agent.

**Claim Forms:** When We receive a notice of claim, We will send forms for filing the claim. If the SubscriberPolicyholder or Insured do not receive these forms within fifteen (15) days, the SubscriberPolicyholder or Insured may send Us a written statement to satisfy this requirement. This statement should include the nature and extent of the claim and be sent to Us within the time stated in the Proof of Loss provision.

**Proof of Loss:** We must receive written proof of loss within ninety (90) days of a claim. If it is not possible for proof to be provided within the ninety (90) days, We will not deny a claim for this reason if We receive the proof as soon as possible. In any event, We must receive proof no later than one year from the time specified, unless SubscriberPolicyholder is legally incapacitated.

**Time of Payment of Claims:** Indemnities payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this Policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

**Payment of Claims:** All payments will be made to SubscriberPolicyholder or Insured's provider.

**Legal Actions:** A legal action may not be brought against Us before sixty (60) days, or after three (3) years, from the date written proof of loss is required to be given.

**Time Limit on Certain Defenses:** After this Policy has been in force for two (2) years, We will not use any statements made in the application of the Policyholder to void the Policy.—After an Insured Person has been covered under this Policy for two (2) years, We will not use any statement made in the Insured Person's enrollment form to defend a claim.

**Misstatement of Age:** If the age of any individual covered under the Policy has been misstated, there shall be an adjustment of premium for the Policy so that there shall be paid to Us the premium for the coverage of such individual at his or her correct age, and the amount of the insurance coverage shall not be affected.

**Worker's Compensation:** The Policy is not in lieu of and does not affect any requirement for coverage by Worker's Compensation Insurance.

**Conformity with State Statutes:** Any provisions of the Policy which are in conflict with the statutes of the state in which the Policy was issued or delivered will be changed to conform to such laws.



**Waiver of Rights:** If We fail to enforce any provision of the Policy, such failure will not affect Our right to do so at a later date, nor will it affect Our right to enforce any other provision of the Policy.

**Inspection of Policy:** The Policy is in the possession of the Policyholder. It may be inspected at any time during business hours at the office of the Policyholder.

**Duty to Cooperate:** As a condition precedent to the payment of benefits hereunder, the ~~Subscriber~~Policyholder and Insured are required to cooperate with Us by providing all information reasonably required to accurately process a claim. Any failure to provide necessary information may result in a denial of benefits for the claim.

## **PART 8 – FILING A DENTAL CLAIM**

**HOW TO FILE A CLAIM:** Claim forms may be obtained from [the BEST Life website located at [www.bestlife.com](http://www.bestlife.com), click on “Forms”].

Submit claims to [BEST Life and Health Insurance Company, P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

For questions about a claim payment, contact [BEST Life’s Customer Service at [1-800-433-0088 or at [cs@bestlife.com](mailto:cs@bestlife.com), Monday through Friday, 7 am to 5 pm Pacific Time].

**CLAIMS DENIAL PROCEDURE:** Any denial of a claim for Benefits will be explained in writing. The explanation will include (a) the specific reason for the denial, (b) reference to the plan provision upon which the denial was based, (c) a description of any additional information that might be required to provide and an explanation of why it is needed, and (d) an explanation of the plan's claim review procedure.

**APPEALING THE DENIAL OF A CLAIM:** You or an authorized representative You appoint to assist or represent You, may appeal any denial of a claim, in whole or in part, for Benefits by filing a written request for a review. The request must include all reasons You believe the initial decision was incorrect and all documentation supporting Your appeal, to [BEST Life and Health Insurance Company, Attn: Appeals, P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

A request for a review must be filed within one-hundred and eighty (180) days after the date on which we issue the written notice of denial of a claim. BEST Life and Health Insurance Company will provide an appeal determination not later than sixty (60) days after receipt of a request for review. If there are special circumstances, the decision will be made as soon as possible, but no later than fifteen (15) days after receipt of the request for review. The appeal determination will be in writing and will include specific reasons for the decision. This decision shall also include specific references to the Policy provisions on which the decision was based.



## [ENDORSEMENT - SUPPLEMENTAL FAMILY DENTAL INSURANCE]

If the Policyholder selected Family Dental Coverage, then this Endorsement modifies, supplements, and becomes a part of the Policy. It provides coverage to the enrolled Eligible Persons who are at least 19 years of age until they reach the maximum eligibility age. Except as expressly provided in this Endorsement, all terms and conditions of the Certificate remain unchanged and in full force and effect.

### Dental Plan Schedule of Benefits For Eligible Persons who are at least 19 years of age until they reach maximum eligibility age

	<u>[BESTOne Dental] [Advantage] [Plus] [Basic]</u> <u>Supplemental Plan</u>	
<u>Benefits Description</u>	<u>In-Network</u> <u>[Network]</u>	<u>Out-of-Network</u>
<u>Annual Maximum</u>	<u>\$[1,000 – 1,500]</u>	
<u>Annual Deductible</u>	<u>\$50</u>	
<u>Basic Services Coinsurance</u>	<u>100%</u>	<u>100%</u>
<u>Intermediate Services Coinsurance</u>	<u>[90-50]%</u>	<u>[90-50]%</u>
<u>Major Services Coinsurance</u>	<u>[60-0]%</u>	<u>[60-0]%</u>

### COVERED SERVICES ON SUPPLEMENTAL DENTAL PLAN

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Policy.

#### CLASS A – Basic Services:

- (1) Routine oral examination and diagnosis not more often than twice every twelve (12) months per individual;
- (2) Bitewing x-rays not more often than once every twelve (12) months per individual;
- (3) Full mouth x-rays or panoramic films are limited to once every five (5) years; any combination of eight (8) or more x-rays (including but not limited to bitewings or periapicals/intraorals) will be combined into a full mouth x-ray series;
- (4) Prophylaxis not more often than once every six (6) months per individual.

#### CLASS B – Intermediate Services:

- (1) Pathology;
- (2) All fillings other than lab fabricated restorations (composite fillings limited to permanent anterior and posterior teeth);
- (3) Emergency palliative treatment;
- (4) Limited oral exam not more than once every six months;
- (5) Simple extraction, excluding orthodontic extractions unless a orthodontic benefits are a Covered Dental Expense on this Plan;

- (6) Surgical extraction, including impaction:
  - (a) erupted tooth;
  - (b) soft tissue impaction;
  - (c) partial bony impaction;
  - (d) complete bony impaction;
- (7) General anesthesia or intravenous sedation when required for complex oral surgical procedures (partial and complete bony impacted extractions only);
- (8) Periodontics (tissues and gums);
- (9) Periodontal exam (not in addition to a routine oral exam);
- (10) Periodontal maintenance (limited to once every six (6) months per individual following active periodontal treatment) and not on the same visit as a routine prophylaxis;
- (11) Periodontal scaling and root planing (limited to once every 36 months and to two (2) quadrants per visit, and not in addition to a routine prophylaxis);
- (12) Endodontics (pulp capping and root canal); and
- (13) Oral surgery:
  - (a) root recovery (surgical removal of residual root);
  - (b) oral antral fistula closure;
  - (c) removal of a dentigerous or odontogenic cyst;
  - (d) incision and drainage of an abscess;
  - (e) removal of lateral exostosis;
  - (f) frenulectomy.

#### **CLASS C - Major Services:**

- (1) Inlays, onlays, crowns and other lab fabricated restorations (not including veneers);
- (2) Porcelain, porcelain fused to metal, or full gold crowns on permanent teeth;
- (3) Full or partial dentures or fixed bridgework or adding teeth to an existing denture, if required because of loss of functional natural teeth while the person is covered for this Benefit. The work must be done within twelve (12) months after the extraction and while this coverage is in force;
- (4) Replacement or alteration of full or partial dentures or fixed bridgework caused by the following while coverage is in force:
  - (a) accidental injury requiring oral surgical treatment, or
  - (b) oral surgical treatment involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus or redundant tissue, provided the replacement or alteration is done within twelve (12) months of the injury or surgical treatment.
- (5) Replacement of a full denture or bridgework if the replacement is made more than seven (7) years after the date of installation, unless:
  - (a) such replacement is made necessary by the initial extraction of an adjoining functional natural tooth; or
  - (b) the prosthesis, while in the oral cavity, has been damaged beyond repair as a result of a non-chewing injury while covered;
- (6) Repair or relining of dentures and bridgework[;
- (7) Implants, as an alternative to a fixed prosthetic, (limited to once in a lifetime per site). The cost of the fixed prosthetic will be applied to the total value of the implant and implant-related procedures, not to exceed the cost of the fixed prosthetic:
  - (a) the surgical placement of endosteal implant body including healing cap, where the bone and soft tissues are sound and healthy;
  - (b) implant supported prosthetics;
  - (c) eposteal and transosteal implants will be covered at the cost of the endosteal implant (if performed, member is responsible for additional fees);
  - (d) bone grafting and tooth extractions, provided the work is done while this coverage is in force;
  - (e) implant maintenance].

## **EXCLUSIONS ON SUPPLEMENTAL DENTAL PLAN**

The following exclusions are not Covered Services. No payments will be made by Us for these services:

- (1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a dentist;
- (2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
- (3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
- (4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;
- (5) Services and supplies begun and not completed prior to the patient's effective date, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
- (6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
- (7) Pulp capping, if in conjunction with the installation of inlays, onlays or crowns and fillings or other lab fabricated restorations; including but not limited to inlays, onlays and crowns, preventative tests and examinations diagnostic casts and oral cancer screenings, and expenses incurred for sedative fillings, including charges for prescribed drugs, pre-medication or analgesia;
- (8) The initial installation of a prosthetic device (a fixed bridge, implant, or denture), including crowns and inlays which form abutments, to replace teeth missing before You were covered under the Policy, except when it also replaces a tooth that is extracted while covered unless such installation commences after You have remained continuously covered under this plan for at least three years immediately prior to the date such installation commences;
- (9) Implants, implant services and implant supported prosthetics;
- (10) Expenses incurred for veneers and related procedures;
- (11) Replacement of a lost or stolen or discarded prosthetic device;
- (12) Adjustment, repairs or relines of prostheses for a period of one (1) year from initial placement if the prostheses were paid for under this plan;
- (13) Expenses incurred for a core buildup will only be considered in conjunction with a crown;
- (14) If multiple endodontic treatments are necessary on the same tooth within a period of one (1) year, the allowance will be made for only one (1) procedure;
- (15) X-rays are considered an integral part of the endodontic procedure rather than a separate service and are therefore not eligible for benefits;
- (16) The extraction of immature erupting third molars and non-pathologic, asymptomatic third molar extractions;
- (17) Expenses for gross debridement allowed one time at the beginning of the periodontal treatment plan prior to pocket depth charting;
- (18) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
- (19) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are a Covered Dental Expense on this Plan;

- (20) Surgical procedures incidental to orthodontic treatment, including but not limited to, extraction of teeth solely for orthodontic reasons, exposure of impacted teeth, correction of micrognathia or macrognathia, or repair of cleft palate;
- (21) Charges for service provided for temporomandibular joint dysfunction (TMJ);
- (22) Expenses incurred for congenital or developmental malformations;
- (23) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
- (24) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits;
- (25) Chemotherapeutic agents and any other experimental procedures;
- (26) Charges in excess of the In-Network Provider Fee Schedule for the services in the area where treatment was received or charges in excess of the Calendar Year Maximum amount stated in the "Schedule of Dental Benefits" section of this Plan;
- (27) Expenses that are applied toward satisfaction of a Deductible, if any;
- (28) Services and supplies performed outside of the United States of America;
- (29) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, Your lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;
- (30) Expenses for services for which You would not legally have to pay if there were no insurance;
- (31) Services not completed on or before the date of termination;
- (32) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
- (33) Any service or procedure not commonly found within the scope of practice by a licensed dentist. Such procedures are identified within the current Common Dental Terminology (CDT Codes) published by the American Dental Association;
- (34) Expenses incurred for services covered on a pediatric only dental plan.]

Underwritten by BEST Life and Health Insurance Company

#### **PART 8—FILING A DENTAL CLAIM**

**HOW TO FILE A CLAIM:** Claim forms may be obtained from [the BEST Life website located at [www.bestlife.com](http://www.bestlife.com), click on "Forms"].—

Submit claims to [BEST Life and Health Insurance Company], [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

For questions about a claim payment, contact BEST Life's Customer Service at [1-800-433-0088 or at [cs@bestlife.com](mailto:cs@bestlife.com), Monday through Friday, 7 am to 5 pm Pacific Time].

**CLAIMS DENIAL PROCEDURE:** Any denial of a claim for Benefits will be explained in writing. The explanation will include (a) the specific reason for the denial, (b) reference to the plan provision upon which the denial was based, (c) a description of any additional information that might be required to provide and an explanation of why it is needed, and (d) an explanation of the plan's claim review procedure.

**APPEALING THE DENIAL OF A CLAIM:** You or an authorized representative You appoint to assist or represent You, may appeal any denial of a claim, in whole or in part, for Benefits by filing a written request for a review. The request must include all reasons You believe the initial decision was incorrect and all documentation supporting Your appeal, to BEST Life and Health Insurance Company, Attn: Appeals, [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

A request for a review must be filed within one hundred and eighty (180) days after the date on which we issue the written notice of denial of a claim. BEST Life and Health Insurance Company will provide an appeal determination not later than sixty (60) days after receipt of a request for review. If there are special circumstances, the decision will be made as soon as possible, but no later than fifteen (15) days after receipt of the request for review. The appeal determination will be in writing and will include specific reasons for the decision. This decision shall also include specific references to the Policy provisions on which the decision was based.



~~Underwritten by BEST Life and Health Insurance Company~~

**Individually Underwritten  
Association Insurance Policy**

**Dental PPO Plan**



[2505 McCabe Way  
Irvine, California 92614]

**Notice to Buyer: This Policy provides dental coverage only.**



**BEST Life and Health Insurance Company**  
[2505 McCabe Way  
Irvine, California 92614]

A STOCK COMPANY  
(Herein called the Company)

~~BEST Life and Health Insurance Company, in consideration of the application of the Subscribing Employer and the payment of premiums as due, agrees, subject to the terms and conditions of this Group Policy, to insure Eligible Employees of Subscribing Employers to the Group Policyholder and their eligible Dependents under this Group Policy.~~

~~**GOVERNING JURISDICTION:** The Group Policy is issued in the State of California. Its terms are governed by and shall be construed in accordance with the laws of the Governing Jurisdiction.~~

~~This Group Policy becomes effective at 12:01 a.m., Standard Time at the office of the Group Policyholder on the Group Policy Effective Date in the State of Delivery specified below. Subject to the terms and conditions of this Group Policy, it can be renewed until the First Renewal Date by timely payment of the required premium by the Group Policyholder. Unless terminated in accordance with the applicable provision of this Group Policy, it can be renewed after such time from month to month, subject to the terms and conditions of this Group Policy, by timely payment of the required premium.~~

~~**NOTICE OF TEN DAY RIGHT TO EXAMINE:** We want You to fully understand and be satisfied with the insurance coverage. If for any reason You are not satisfied, You may return this Group Policy to the agent or to Our home office within ten days of receipt and the premium will be fully refunded. Coverage will then be void retroactive to the Insurance Effective Date.~~

~~-  
This Group Policy may be modified by mutual agreement between the Group Policyholder and Us.~~

~~The provisions and the terms in the Certificate are part of this Group Policy. A copy of the Certificate is attached to, and made a part of this Group Policy.~~

~~Signed for BEST Life and Health Insurance Company by its President and Secretary at [2505 McCabe Way, Irvine, California 92614.]~~

BEST Life and Health Insurance Company ("BEST Life") is issuing this Policy in consideration of the accuracy of representations made in Your application and Your payment of premiums for Policy coverage.

**READ YOUR POLICY CAREFULLY:** This Policy is a legal contract between You (owner of this Policy) and Us.

**GOVERNING JURISDICTION:** The Policy is issued in the State of Tennessee. It shall be construed in accordance with the laws of the issuing State.

**NOTICE OF TEN DAY RIGHT TO EXAMINE:** We want You to fully understand and be satisfied with the insurance coverage. If for any reason You are not satisfied, You may return this Policy to Your agent or to Our home office within ten (10) days of receipt and Your premium will be fully refunded. Coverage will then be void retroactive to the Insurance Effective Date.

**RENEWAL AND PREMIUM PAYMENT PROVISIONS:** You may renew this Policy for additional coverage periods by paying the premium when due or within the Grace Period until the Insureds reach

age [19][65]. Each period of coverage runs from premium due date to premium due date. We reserve the right to change premiums. Any such change will be made according to the table of premium rates that will apply to all policies with the same form and class in Your State. All future renewal premiums will be based on Your original issue age. We will notify You of any premium rate increase at least sixty (60) days in advance. We cannot cancel this Policy while it is in force.

**IN WITNESS WHEREOF**, We have caused this Policy to be signed by Our President and Our Secretary. This Policy takes effect at 12:01 a.m. at Your residence on its Effective Date. This Policy terminates at 12:01 a.m. on the date any renewal premium is due and not paid, subject to the Grace Period.

[



President

||



Secretary

Group PPO  
Pediatric Dental Policy  
Non-Participating

~~Group Policyholder: BEST Employers Association~~

~~Group Policy Effective Date: [XX XX XXXX] Group Policy Number: [XXX]~~

~~State of Delivery: California~~

~~Premiums Due On: 1<sup>st</sup> of each month First Renewal Date: [XX XX XXXX]~~

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This Policy Is Not Valid  
Unless There Is a Complete Statement of Coverage

Statement of Coverage

DENTAL

INSURANCE SUBSCRIBER NAME: [JOHN D. DOE]  
POLICY EFFECTIVE DATE: [01/01/2014]

INSURED NAME(S) AND EFFECTIVE DATE(S):

[JANE DOE 01/01/2014]

[JON DOE 01/01/2014]

[PLAN: [PPO HIGH]

DEDUCTIBLE: [\$50]

ANNUAL MAXIMUM: [\$1,000]

PEDIATRIC DENTAL PLAN: [PPO HIGH]

DEDUCTIBLE: [\$50]

OUT OF POCKET MAXIMUM: [\$700]

POLICY NO.: [XXXXXXXXXX]

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## PART 1 - SCHEDULE OF BENEFITS

This ~~Certificate of Group Coverage Policy~~ is made valid on the effective dates shown for the listed Insureds on the Statement of Coverage.

~~The Policy is issued by BEST Life and Health Insurance Company to: [BEST Employers Association].~~

Covered Services received by Insured from a Network Provider are reimbursed at the Network Provider's contracted Fee Schedule. Covered Services received by Insured from an Out-of-Network Provider are reimbursed at the [80th or 90th] percentile of a Usual, Reasonable and Customary schedule. All Covered Services are subject to Cost Sharing as shown on this Schedule of Benefits.

{

<del>[PPO Dental High] Plan</del>		
<del>Benefits Description</del>	<del>In-Network [Network]</del>	<del>Out-of-Network</del>
<del>Employer Contributory or Voluntary</del>	<del>[Employer contributory][Voluntary]</del>	
<del>Annual Maximum</del>	<del>[\$1,000 — 1,500]</del>	
<del>Annual Deductible— (Applies to Basic and Major)—3 Deductible- Maximum per Family</del>	<del>\$50</del>	
<del>Preventive Care Services Routine oral exam, cleanings, X rays</del>	<del>100%</del>	<del>100%</del>
<del>Basic Services— Fillings (amalgam, porcelain &amp; plastic), anterior &amp; posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology</del>	<del>90%</del>	<del>80%</del>
<del>Major Services— Crowns &amp; gold fillings, inlays, onlays &amp; pontics, implants, fixed bridges, complete &amp; partial dentures</del>	<del>60%</del>	<del>50%</del>
<del>Major Services Waiting Period</del>	<del>12 Months</del>	
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<del>Periodontic Services</del>	<del>Major</del>	
<del>Oral Surgery Services</del>	<del>Major</del>	
<del>Dental Accident Benefit</del>	<del>\$1,000</del>	
<del>Child Orthodontic Coverage Orthodontic Services Coinsurance Orthodontic Maximums—Calendar Year + Lifetime 12 Month Waiting Period</del>	<del>50% \$500 + \$1,000</del>	
<del>Usual and Customary Reimbursement</del>	<del>Fee Schedule</del>	<del>80<sup>th</sup> Percentile</del>

}

{		
	<b>[PPO-Dental Mid]-Plan</b>	
<b>Benefits Description</b>	<b>In-Network {Network}</b>	<b>Out-of-Network</b>
<b>Employer Contributory or Voluntary</b>	{Employer-contributory}{Voluntary}	
<b>Annual Maximum-</b>	\$1,500	
<b>Annual Deductible-</b> (Applies to Basic and Major)—3 Deductible- Maximum per Family	\$50	
<b>Preventive Care Services</b> Routine oral exam, cleanings, X rays-	100%	80%
<b>Basic Services-</b> Filings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology	80%	80%
<b>Major Services-</b> Crowns & gold filings, inlays, onlays & pontics, implants, fixed bridges, complete & partial dentures	50%	50%
<b>Major Services Waiting Period</b>	12 Months	
<b>Endodontic Services</b>	Major	
<b>Periodontic Services</b>	Major	
<b>Oral Surgery Services</b>	Major	
<b>Dental Accident Benefit</b>	\$1,000	
<b>Child Orthodontic Coverage</b> Orthodontic Services Coinsurance Orthodontic Maximums — Calendar Year   Lifetime 12 Month Waiting Period	50% \$500   \$1,000	
<b>Usual and Customary Reimbursement</b>	Fee Schedule	80 <sup>th</sup> Percentile
}		
{		
	<b>[PPO-Dental Basic]-Plan</b>	
<b>Benefits Description</b>	<b>In-Network {Network}</b>	<b>Out-of-Network</b>
<b>Employer Contributory or Voluntary</b>	{Employer-contributory}{Voluntary}	
<b>Annual Maximum-</b>	\$1,000	
<b>Annual Deductible-</b> (Applies to Basic and Major)—3 Deductible- Maximum per Family	\$50	
<b>Preventive Care Services</b> Routine oral exam, cleanings, X rays-	100%	80%
<b>Basic Services-</b> Filings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology	80%	50%
<b>Major Services-</b> Crowns & gold filings, inlays, onlays & pontics, implants, fixed bridges, complete & partial dentures	0%	0%
<b>Endodontic Services</b>	Major	
<b>Periodontic Services</b>	Major	
<b>Oral Surgery Services</b>	Major	
<b>Dental Accident Benefit</b>	\$1,000	
<b>Usual and Customary Reimbursement</b>	Fee Schedule	80 <sup>th</sup> Percentile



}  
{

	<b>[PPO Dental Value] Plan</b>	
<b>Benefits Description</b>	<b>In-Network [Network]</b>	<b>Out-of-Network</b>
<b>Employer Contributory or Voluntary</b>	<b>[Employer contributory][Voluntary]</b>	
<b>Annual Maximum</b>	<b>\$1,000</b>	
<b>Annual Deductible</b> (Applies to Basic and Major) — 3 Deductible- Maximum per Family	<b>\$50</b>	
<b>Preventive Care Services</b> Routine oral exam, cleanings, X rays	<b>100%</b>	<b>80%</b>
<b>Basic Services</b> Fillings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology	<b>50%</b>	<b>20%</b>
<b>Major Services</b> Crowns & gold fillings, inlays, onlays & pontics, implants, fixed bridges, complete & partial dentures	<b>0%</b>	<b>0%</b>
<b>Endodontic Services</b>	<b>Major</b>	
<b>Periodontic Services</b>	<b>Major</b>	
<b>Oral Surgery Services</b>	<b>Major</b>	
<b>Dental Accident Benefit</b>	<b>\$1,000</b>	
<b>Usual and Customary Reimbursement</b>	<b>Fee Schedule</b>	<b>80<sup>th</sup> Percentile</b>

}

## **PART 2 — BENEFITS**

### **Covered Services**

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Certificate.

#### **CLASS I — Preventive Dental Procedures include:**

- (1) — Routine oral examination and diagnosis not more often than twice every 12 months per individual;
- (2) — Bitewing x rays not more often than once every 12 months per individual;
- (3) — Full mouth x rays or panoramic films are limited to once every five years; any combination of eight or more x rays (including but not limited to bitewings or periapicals/intraorals) will be combined into a full mouth x-ray series;
- (4) — Prophylaxis not more often than once every six months per individual.

#### **CLASS II — Basic Dental Procedures include:**

- (1) — Pathology;
- (2) — All fillings other than lab fabricated restorations (composite fillings limited to permanent anterior and posterior teeth);
- (3) — Emergency palliative treatment;
- (4) — Limited oral exam not more than once every six months;
- (5) — Simple extraction, excluding orthodontic extractions unless a orthodontic benefits are a Covered Dental Expense on this Plan;
- (6) — Surgical extraction, including impaction;

- ~~(a) erupted tooth;~~
- ~~(b) soft tissue impaction;~~
- ~~(c) partial bony impaction;~~
- ~~(d) complete bony impaction;~~
- ~~(7) General anesthesia or intravenous sedation when required for complex oral surgical procedures (partial and complete bony impacted extractions only);~~
- ~~(8) Periodontics (tissues and gums);~~
- ~~(9) Periodontal exam (not in addition to a routine oral exam);~~
- ~~(10) Periodontal maintenance (limited to once every six months per individual following active periodontal treatment) and not on the same visit as a routine prophylaxis;~~
- ~~(11) Periodontal scaling and root planing (limited to once every 36 months and to two quadrants per visit, and not in addition to a routine prophylaxis);~~
- ~~(12) Endodontics (pulp capping and root canal); and~~
- ~~(13) Oral surgery:~~
  - ~~(a) root recovery (surgical removal of residual root);~~
  - ~~(b) oral antral fistula closure;~~
  - ~~(c) removal of a dentigerous or odontogenic cyst;~~
  - ~~(d) incision and drainage of an abscess;~~
  - ~~(e) removal of lateral exostosis;~~
  - ~~(f) frenulectomy.~~

[**Note:** Unless the twelve (12) month waiting period requirement for Major Dentistry services has been met, the services below are not covered benefits for any treatment that began during the twelve (12) month period immediately following Your effective date of coverage.]

**CLASS III—Major Dental Procedures include:**

- ~~(1) Inlays, onlays, crowns and other lab fabricated restorations (not including veneers);~~
- ~~(2) Porcelain, porcelain fused to metal, or full gold crowns on permanent teeth;~~
- ~~(3) Full or partial dentures or fixed bridgework or adding teeth to an existing denture, if required because of loss of functional natural teeth while the person is covered for this Benefit. The work must be done within 12 months after the extraction and while this coverage is in force;~~
- ~~(4) Replacement or alteration of full or partial dentures or fixed bridgework caused by the following while coverage is in force:~~
  - ~~(a) accidental injury requiring oral surgical treatment; or~~
  - ~~(b) oral surgical treatment involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus or redundant tissue, provided the replacement or alteration is done within 12 months of the injury or surgical treatment.~~
- ~~(5) Replacement of a full denture or bridgework if the replacement is made more than seven years after the date of installation, unless:~~
  - ~~(a) such replacement is made necessary by the initial extraction of an adjoining functional natural tooth; or~~
  - ~~(b) the prosthesis, while in the oral cavity, has been damaged beyond repair as a result of a non-chewing injury while covered;~~
- ~~(6) Repair or reline of dentures and bridgework;~~
- ~~(7) Implants, as an alternative to a fixed prosthetic, (limited to once in a lifetime per site). The cost of the fixed prosthetic will be applied to the total value of the implant and implant-related procedures, not to exceed the cost of the fixed prosthetic:~~
  - ~~(a) the surgical placement of endosteal implant body including healing cap, where the bone and soft tissues are sound and healthy;~~
  - ~~(b) implant supported prosthetics;~~
  - ~~(c) eposteal and tranosteal implants will be covered at the cost of the endosteal implant (if~~

- performed, member is responsible for additional fees);
- (d) bone grafting and tooth extractions, provided the work is done while this coverage is in force;
- (e) implant maintenance.

[**Note:** Unless the twelve (12) month waiting period requirement for Orthodontic Procedures has been met, the services below are not covered benefits for any treatment that begin during the twelve (12) month period immediately following Your effective date of coverage.]

**[CLASS IV—Orthodontic Procedures Include:**

Provides orthodontic treatment for Dependent children until the end of the month of their 18<sup>th</sup> birthday, to be payable as follows:

- (1) All procedures performed in connection with orthodontic treatment subject to the coinsurance level, Calendar Year and Lifetime Maximum Benefit as defined in the Schedule of Benefits;
- (2) Benefits for the initial placement up to [1/3][1/2] of the Lifetime Maximum Benefit Amount, as an initial down payment;
- (3) Periodic follow up visits will be payable on a monthly basis during the scheduled course of orthodontic treatment, up to the Lifetime Maximum Amount;
- (4) Orthodontic benefits end once braces are removed or at the cancellation of coverage, whichever comes first.]

**Supplemental Dental Accident Benefit**

This benefit provides 100% coverage, not subject to deductible or coinsurance, for injury to sound, natural teeth up to a maximum benefit amount of \$1,000. Predetermination must be submitted before benefits are payable.

**[Pediatric Dental Plan Schedule of Benefits  
For Children to Age 19]**

	<b><u>[BEST Life Child Dental] [Plus] Pediatric Dental Plan</u></b>	
<b><u>Procedure Categories</u></b>	<b><u>In-Network [Network Name]</u></b>	<b><u>Out-of-Network</u></b>
<b><u>Out-of-Pocket Maximum</u></b>	\$700 for 1 Child \$1,400 for 2 or more Children	\$700 for 1 Child \$1,400 for 2 or more Children
<b><u>Annual Deductible – Applies to Preventive[,] [services received Out-of-Network as well as] Basic and Major services received In-Network or Out-of-Network</u></b>	\$[0][50]	\$[50][100]
<b><u>Diagnostic &amp; Preventive Services Coinsurance – Exams, cleanings, sealants, fluoride treatment, x-rays</u></b>	100%	[90][60]%
<b><u>Basic Services Coinsurance – Fillings</u></b>	[70][55]%	[60][40]%
<b><u>Major Services Coinsurance – Crowns &amp; casts, prosthodontics, endodontics, periodontics, oral surgery</u></b>	[50][35]%	[40][20]%
<b><u>Orthodontic Services Coinsurance (Medically necessary Orthodontic Services only)</u></b>	50% [24 Month Wait]	50% [24 Month Wait]

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**[Dental Plan Schedule of Benefits  
For Adults and Dependent Children between 19 and 26]**

	<b><u>[BESTOne Dental] [Advantage][Plus][Basic] Supplemental Plan</u></b>	
<b><u>Benefits Description</u></b>	<b><u>In-Network [Network]</u></b>	<b><u>Out-of-Network</u></b>
<b><u>Annual Maximum</u></b>	<b><u>[\$500 – 3,500]</u></b>	
<b><u>Annual Deductible</u></b> (Applies to Basic and Major) – 3 Deductible Maximum per Family	<b><u>[\$0-100]</u></b>	
<b><u>Preventive Care Services</u></b> Routine oral exam, cleanings, X-rays	<b><u>[100-70]%</u></b>	<b><u>[100-70]%</u></b>
<b><u>Basic Services</u></b> Fillings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology	<b><u>[90-50]%</u></b>	<b><u>[80-20]%</u></b>
<b><u>Major Services</u></b> Crowns & gold fillings, inlays, onlays & pontics, [implants,] fixed bridges, complete & partial dentures	<b><u>[60-0]%</u></b>	<b><u>[50-0]%</u></b>
<b><u>[Major Services Waiting Period]</u></b>	<b><u>12 Months]</u></b>	
<b><u>Endodontic Services</u></b>	<b><u>[Basic][Major]</u></b>	
<b><u>Periodontic Services</u></b>	<b><u>[Basic][Major]</u></b>	
<b><u>Oral Surgery Services</u></b>	<b><u>[Basic][Major]</u></b>	
<b><u>Usual and Customary Reimbursement</u></b>	<b><u>Fee Schedule</u></b>	<b><u>[80<sup>th</sup>][90<sup>th</sup>] Percentile</u></b>

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**PART 2 - BENEFITS AND EXCLUSIONS**

**COVERED SERVICES ON  
PEDIATRIC DENTAL PLAN**

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Policy.

**Class I – Preventive and Diagnostic Procedures Include:**

- (1) Prophylaxis not more often than once every six (6) months;
- (2) Topical application of fluoride (excluding prophylaxis) not more often than twice every twelve (12) months;
- (3) Topical fluoride varnish not more often than twice every twelve (12) months;
- (4) Sealants not more often than once per tooth in a thirty-six (36) month period and limited to unrestored permanent molars for individuals under age nineteen (19);
- (5) Space maintainers, including re-cementation, for individuals under age nineteen (19) (excluding removal of fixed space maintainer);
- (6) Periodic oral evaluation not more often than once every six (6) months;
- (7) Limited oral evaluation (problem focused) not more often than once every six (6) months;
- (8) Comprehensive oral evaluation not more often than once every six (6) months;
- (9) Comprehensive periodontal evaluation not more often than once every six (6) months;
- (10) Intraoral complete X-rays or panoramic film not more often than once in a 60-month period;
- (11) Bitewing X-rays not more often than one set every six (6) months;
- (12) Single film intraoral periapical or occlusal;

(13) Palliative treatment of dental pain (minor procedure);

**Class II – Basic Procedures Include:**

- (1) Amalgams, resin-based composites, re-cement inlays, re-cement crowns, protective restoration, pin retention;
- (2) Prefabricated stainless steel crowns not more often than once per tooth in a sixty (60) month period for individuals under age fifteen (15);
- (3) Therapeutic pulpotomy (excluding restoration) if a root canal is not performed within forty-five (45) days of the pulpotomy;
- (4) Partial pulpotomy for apexogenesis limited to permanent tooth with incomplete root development, if a root canal is not performed within forty-five (45) days of pulpotomy;
- (5) Pulpal therapy (excluding final restoration) once per tooth per lifetime, limited to primary incisor teeth for individuals up to age six (6), and limited to primary molars and cuspids for individuals up to age eleven (11);
- (6) Periodontal scaling and root planning, per quadrant, not more often than once every twenty-four (24) months;
- (7) Periodontal maintenance not more often than four in a twelve (12)-month period, combined with adult prophylaxis after the completion of active periodontal therapy;
- (8) Adjustment and repair of complete or partial dentures;
- (9) Rebase and reline not more often than once in a thirty-six (36) month period, six (6) months after initial installation;
- (10) Tissue conditioning;
- (11) Recement fixed partial denture
- (12) Fixed partial denture repair, by report;
- (13) Oral surgery:
  - a. extraction for erupted tooth or exposed root;
  - b. surgical removal of erupted tooth;
  - c. removal of impacted tooth;
  - d. removal of residual tooth roots;
  - e. coronectomy;
  - f. tooth reimplantation;
  - g. surgical access of unerupted tooth;
  - h. alveoloplasty;
  - i. removal of exostosis;
  - j. incision and drainage of abscess;
  - k. suture of recent small wounds up to five (5) cm
  - l. excision of pericoronal gingival;

**Class III – Major Procedures Include:**

- (1) Detailed and extensive oral evaluation;
- (2) Inlays, onlays, crowns, core buildup, including any pins, prefabricated post and core in addition to crown, limited to one per tooth every sixty (60) months;
- (3) Endodontics (root canal)
- (4) Gingivectomy or gingivoplasty, four (4) or more teeth not more often than once every thirty-six (36) months;
- (5) Gingival flap procedure, four (4) or more teeth not more often than once every thirty-six (36) months;
- (6) Osseous surgery, four (4) or more contiguous teeth or bounded teeth spaces per quadrant, not more often than once every thirty-six (36) months;
- (7) Full mouth debridement limited to one (1) per lifetime;

- (8) Complete and partial dentures, including abutments, pontics, onlays, retainers and crowns, not more often than once every sixty (60) months (excludes interim dentures);
- (9) Implants and implant services once every sixty (60) months only if medically necessary;
- (10) Occlusal guard not more often than once in twelve (12) months for individuals thirteen (13) and older with predetermination only;
- (11) General anesthesia or IV sedation;
- (12) Consultation by dentist or physician other than the dentist providing treatment;
- (13) Therapeutic drug injection with predetermination;
- (14) Treatment of post-surgical complications with predetermination.

[Note: Unless the twenty-four (24) month waiting period requirement for Medically Necessary Orthodontic services has been met, the services below are not covered benefits for any treatment that began during the twenty-four (24) month period immediately following Your effective date of coverage.]

**Class IV – Medically Necessary Orthodontic Procedures Include:**

- (1) For orthodontia services associated with the repair of cleft palate and palate or other severe craniofacial defects or injury for which the function of speech, swallowing or chewing is restored;
- (2) Requires predetermination; and
- (3) Coverage includes diagnosis, treatment plan, anticipated treatment time and cost estimate.

**EXCLUSIONS ON  
PEDIATRIC DENTAL PLAN**

The following exclusions are not Covered Services. No payments will be made by Us for these services:

- (1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a dentist;
- (2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
- (3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
- (4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;
- (5) Services and supplies started and not completed before the patient was covered under this Plan, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
- (6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
- (7) Space maintainers;
- (8) Sealants if re-sealed within a five (5) year period;
- (9) Retreatment of a previous root canal or apicoectomy/periradicular surgery;
- (10) Elective tooth extractions;
- (11) Separate payments for open and drain palliative procedure when the root canal is completed on the same date of service;
- (12) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are defined as a Covered Dental Expense;
- (13) Charges in excess of Usual, Reasonable and Customary charges amount stated in the "Schedule

- of Benefits” section of this Plan, or in excess of the Preferred Provider Fee Schedule;
- (14) Charges for service provided for temporomandibular joint dysfunction (TMJ);
  - (15) Expenses incurred for congenital or developmental malformations, except as defined as a Covered Orthodontic Expense;
  - (16) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits, except as defined as a Covered Orthodontic Expense;
  - (17) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
  - (18) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, the patient's lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;
  - (19) Expenses for services for which the patient would not legally have to pay if there were no insurance, unless mandated by the State;
  - (20) Services not completed on or before the date of termination;
  - (21) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
  - (22) Expenses that are applied toward satisfaction of a Deductible, if any;
  - (23) Any service or procedure not commonly found within the scope of practice by a licensed dentist;
  - (24) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
  - (25) Chemotherapeutic agents and any other experimental procedures;
  - (26) Expenses incurred for veneers and related procedures;
  - (27) Services and supplies performed outside of the United States of America.

#### **[COVERED SERVICES ON SUPPLEMENTAL DENTAL PLAN**

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Policy.

#### **CLASS I - Preventive Dental Procedures include:**

- (1) Routine oral examination and diagnosis not more often than twice every twelve (12) months per individual;
- (2) Bitewing x-rays not more often than once every twelve (12) months per individual;
- (3) Full mouth x-rays or panoramic films are limited to once every five (5) years; any combination of eight (8) or more x-rays (including but not limited to bitewings or periapicals/intraorals) will be combined into a full mouth x-ray series;
- (4) Prophylaxis not more often than once every six (6) months per individual.

#### **CLASS II - Basic Dental Procedures include:**

- (1) Pathology;
- (2) All fillings other than lab fabricated restorations (composite fillings limited to permanent anterior and posterior teeth);
- (3) Emergency palliative treatment;
- (4) Limited oral exam not more than once every six months;
- (5) Simple extraction, excluding orthodontic extractions unless a orthodontic benefits are a Covered Dental Expense on this Plan;



- (6) Surgical extraction, including impaction:
  - (a) erupted tooth;
  - (b) soft tissue impaction;
  - (c) partial bony impaction;
  - (d) complete bony impaction;
- (7) General anesthesia or intravenous sedation when required for complex oral surgical procedures (partial and complete bony impacted extractions only);
- (8) Periodontics (tissues and gums);
- (9) Periodontal exam (not in addition to a routine oral exam);
- (10) Periodontal maintenance (limited to once every six (6) months per individual following active periodontal treatment) and not on the same visit as a routine prophylaxis;
- (11) Periodontal scaling and root planing (limited to once every 36 months and to two (2) quadrants per visit, and not in addition to a routine prophylaxis);
- (12) Endodontics (pulp capping and root canal); and
- (13) Oral surgery:
  - (a) root recovery (surgical removal of residual root);
  - (b) oral antral fistula closure;
  - (c) removal of a dentigerous or odontogenic cyst;
  - (d) incision and drainage of an abscess;
  - (e) removal of lateral exostosis;
  - (f) frenulectomy.

[Note: Unless the twelve (12) month waiting period requirement for Major Dentistry services has been met, the services below are not covered benefits for any treatment that began during the twelve (12) month period immediately following Your effective date of coverage.]

**CLASS III - Major Dental Procedures include:**

- (1) Inlays, onlays, crowns and other lab fabricated restorations (not including veneers);
- (2) Porcelain, porcelain fused to metal, or full gold crowns on permanent teeth;
- (3) Full or partial dentures or fixed bridgework or adding teeth to an existing denture, if required because of loss of functional natural teeth while the person is covered for this Benefit. The work must be done within twelve (12) months after the extraction and while this coverage is in force;
- (4) Replacement or alteration of full or partial dentures or fixed bridgework caused by the following while coverage is in force:
  - (a) accidental injury requiring oral surgical treatment, or
  - (b) oral surgical treatment involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus or redundant tissue, provided the replacement or alteration is done within twelve (12) months of the injury or surgical treatment.
- (5) Replacement of a full denture or bridgework if the replacement is made more than seven (7) years after the date of installation, unless:
  - (a) such replacement is made necessary by the initial extraction of an adjoining functional natural tooth; or
  - (b) the prosthesis, while in the oral cavity, has been damaged beyond repair as a result of a non-chewing injury while covered;
- (6) Repair or reline of dentures and bridgework;
- (7) Implants, as an alternative to a fixed prosthetic, (limited to once in a lifetime per site). The cost of the fixed prosthetic will be applied to the total value of the implant and implant-related procedures, not to exceed the cost of the fixed prosthetic:
  - (a) the surgical placement of endosteal implant body including healing cap, where the bone and soft tissues are sound and healthy;
  - (b) implant supported prosthetics;

- (c) eposteal and transosteal implants will be covered at the cost of the endosteal implant (if performed, member is responsible for additional fees);
- (d) bone grafting and tooth extractions, provided the work is done while this coverage is in force;
- (e) implant maintenance].

### **EXCLUSIONS ON SUPPLEMENTAL DENTAL PLAN**

The following exclusions are not Covered Services. No payments will be made by Us for these services:

- (1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;
- (2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
- (3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
- (4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;
- (5) Services and supplies begun and not completed prior to the patient's effective date, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
- (6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
- (7) Pulp capping, if in conjunction with the installation of inlays, onlays or crowns and fillings or other lab fabricated restorations; including but not limited to inlays, onlays and crowns, preventative tests and examinations diagnostic casts and oral cancer screenings, and expenses incurred for sedative fillings, including charges for prescribed drugs, pre-medication or analgesia;
- (8) The initial installation of a prosthetic device (a fixed bridge, implant, or denture), including crowns and inlays which form abutments, to replace teeth missing before You were covered under the Policy, except when it also replaces a tooth that is extracted while covered unless such installation commences after You have remained continuously covered under this plan for at least three years immediately prior to the date such installation commences;
- (9) Implants, implant services and implant supported prosthetics[ are not covered for patients under the age of sixteen (16)];
- (10) Expenses incurred for veneers and related procedures;
- (11) Replacement of a lost or stolen or discarded prosthetic device;
- (12) Adjustment, repairs or relines of prostheses for a period of one (1) year from initial placement if the prostheses were paid for under this plan;
- (13) Expenses incurred for a core buildup will only be considered in conjunction with a crown;
- (14) If multiple endodontic treatments are necessary on the same tooth within a period of one (1) year, the allowance will be made for only one (1) procedure;
- (15) X-rays are considered an integral part of the endodontic procedure rather than a separate service and are therefore not eligible for benefits;
- (16) The extraction of immature erupting third molars and non-pathologic, asymptomatic third molar extractions;
- (17) Expenses for gross debridement allowed one time at the beginning of the periodontal treatment plan prior to pocket depth charting;

- (18) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
- (19) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are a Covered Dental Expense on this Plan;
- (20) Surgical procedures incidental to orthodontic treatment, including but not limited to, extraction of teeth solely for orthodontic reasons, exposure of impacted teeth, correction of micrognathia or macrognathia, or repair of cleft palate;
- (21) Charges for service provided for temporomandibular joint dysfunction (TMJ);
- (22) Expenses incurred for congenital or developmental malformations;
- (23) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
- (24) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits;
- (25) Chemotherapeutic agents and any other experimental procedures;
- (26) Charges in excess of Usual, Reasonable and Customary charges or in excess of the Calendar Year Maximum amount stated in the "Schedule of Dental Benefits" section of this Plan, or in excess of the Preferred Provider Fee Schedule;
- (27) Expenses that are applied toward satisfaction of a Deductible, if any;
- (28) Services and supplies performed outside of the United States of America;
- (29) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, Your lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;
- (30) Expenses for services for which You would not legally have to pay if there were no insurance;
- (31) Services not completed on or before the date of termination;
- (32) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
- (33) Any service or procedure not commonly found within the scope of practice by a licensed dentist. Such procedures are identified within the current Common Dental Terminology (CDT Codes) published by the American Dental Association;
- (34) Expenses incurred for services covered on a pediatric only dental plan.]

## **PART 3 - LIMITATIONS AND COST SHARING**

### **ACCESS TO CARE**

#### **Using a Network Provider:**

BEST Life offers Insureds the option to save on out-of-pocket costs when care is provided by a Network Provider. A listing of General Dentists and Specialists is available. To find a Network Provider, please refer to the Network information provided on the ID Card.

#### **How to Select a Dentist:**

Insureds on this Plan may obtain dental services from any licensed dental professional in the United States. To use the Plan, Insureds may directly contact the dentist of their choice and make an appointment. Insureds are advised to bring their ID Card to their appointment. The dentist may require a copy of the Insured's ID Card to confirm eligibility on this Plan.

#### **How to Obtain a Referral:**

A dentist may determine that an Insured requires treatment from a dental provider that specializes in a type of dentistry (Specialist). The Insured does not need to contact BEST Life for a referral. The Insured can directly contact the Specialist to make an appointment. The Specialist may require

information from the Insured's dentist to determine a treatment plan and may contact the dentist directly.

### ADVANCE NOTICE OF DENTAL TREATMENT

Subscriber or Insured should submit Advance Notice of Dental Treatment before treatment commences in order to obtain Predetermination of Covered Services, including services that are medically necessary. If dental services are performed without such Predetermination, We reserve the right to deny any claim submitted with respect to such Covered Services; provided however, that predetermination is not required for:

- (1) Covered Services for which the related expense is less than \$500 during any course of treatment ("course of treatment" means one treatment or one of a planned series of treatments resulting from dental examination);
- (2) Emergency treatment; or
- (3) Oral examination and prophylaxis.

Predetermination is required for the following dental services:

- (1) Crowns, Anterior, except with posts or root canal;
- (2) Crowns, two (2) or more Posterior, except with posts or root canal;
- (3) Inlays or Onlays, two (2) or more, except with posts or root canal;
- (4) Laminates;
- (5) Anterior composites;
- (6) Two (2) or more multiple surfaces;
- (7) Bridges – initial or replacement;
- (8) Eligible partial dentures – initial or replacement;
- (9) Periodontal surgery over \$500;
- (10) Full bony impactions, two (2) or more.

Predetermination is required for the following dental services for children:

- (1) Medically necessary services or supplies;
- (2) Panoramic film for children under age six (6);
- (3) Periodontal scaling and root planing;
- (4) Occlusal orthotic devices;
- (5) Appliance therapy;
- (6) Orthodontia, including preorthodontic treatment visit.

Predetermination is required for the following dental services for adults and children 19 or older:

- (1) Crowns, Anterior, except with posts or root canal;
- (2) Crowns, 2 or more Posterior, except with posts or root canal;
- (3) Inlays or Onlays, 2 or more, except with posts or root canal;
- (4) Laminates;
- (5) Anterior composites;
- (6) 2 or more multiple surfaces;
- (7) Bridges – initial or replacement;
- (8) Eligible partial dentures – initial or replacement;
- (9) Periodontal surgery over \$500;
- (10) Full bony impactions, 2 or more.

We will have thirty (30) days to furnish the provider with an Explanation of Benefits demonstrating whether

the proposed treatment will be a Covered Service under this Policy.

## DEDUCTIBLES

**Annual Deductible:** The Annual Deductible shown in the Schedule of Dental Benefits will apply separately to each Insured. Each Insured must accumulate eligible expenses equal to the deductible amount.

## ALTERNATIVE PROCEDURES

If more than one treatment plan exists for a dental procedure, covered dental expenses will be based on the least expensive procedure that will produce a result that meets professionally recognized standards. If the Insured's provider elects the more expensive treatment, the Insured or Subscriber shall be responsible for any charges that are greater than the covered expense for the less expensive treatment.

### **PART 4 — EXCLUSIONS**

~~The following exclusions are not Covered Services. No payments will be made by Us for these services:~~

- ~~-~~
- ~~(1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;~~
- ~~(2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;~~
- ~~(3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;~~
- ~~(4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;~~
- ~~(5) Services and supplies begun and not completed prior to the patient's effective date, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;~~
- ~~(6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;~~
- ~~(7) Pulp capping, if in conjunction with the installation of inlays, onlays or crowns and fillings or other lab fabricated restorations; including but not limited to inlays, onlays and crowns, preventative tests and examinations diagnostic casts and oral cancer screenings, and expenses incurred for sedative fillings, including charges for prescribed drugs, pre-medication or analgesia;~~
- ~~(8) The initial installation of a prosthetic device (a fixed bridge, implant, or denture), including crowns and inlays which form abutments, to replace teeth missing before You were covered under the Policy, except when it also replaces a tooth that is extracted while covered unless such installation commences after You have remained continuously covered under this plan for at least three years immediately prior to the date such installation commences;~~
- ~~(9) Implants, implant services and implant supported prosthetics are not covered for patients under the age of 16;~~
- ~~(10) Expenses incurred for veneers and related procedures;~~
- ~~(11) Replacement of a lost or stolen or discarded prosthetic device;~~
- ~~(12) Adjustment, repairs or relines of prostheses for a period of one year from initial placement if the prostheses were paid for under this plan;~~

- ~~(13) Expenses incurred for a core buildup will only be considered in conjunction with a crown;~~
- ~~(14) If multiple endodontic treatments are necessary on the same tooth within a period of one year, the allowance will be made for only one procedure;~~
- ~~(15) X rays are considered an integral part of the endodontic procedure rather than a separate service and are therefore not eligible for benefits;~~
- ~~(16) The extraction of immature erupting third molars and non pathologic, asymptomatic third molar extractions;~~
- ~~(17) Expenses for gross debridement allowed one time at the beginning of the periodontal treatment plan prior to pocket depth charting;~~
- ~~(18) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;~~
- ~~(19) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are a Covered Dental Expense on this Plan;~~
- ~~(20) Surgical procedures incidental to orthodontic treatment, including but not limited to, extraction of teeth solely for orthodontic reasons, exposure of impacted teeth, correction of micrognathia or macrognathia, or repair of cleft palate;~~
- ~~(21) Charges for service provided for temporomandibular joint dysfunction (TMJ);-~~
- ~~(22) Expenses incurred for congenital or developmental malformations;~~
- ~~(23) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);~~
- ~~(24) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits;~~
- ~~(25) Chemotherapeutic agents and any other experimental procedures;~~
- ~~(26) Charges in excess of Usual, Reasonable and Customary charges or in excess of the Calendar Year Maximum amount stated in the "Schedule of Dental Benefits" section of this Plan, or in excess of the Preferred Provider Fee Schedule;~~
- ~~(27) Expenses that are applied toward satisfaction of a Deductible, if any;~~
- ~~(28) Services and supplies performed outside of the United States of America;~~
- ~~(29) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, Your lawful spouse, domestic partner, child, child of Your domestic partner, parent, step parent, grandparent, brother, sister, cousin or in-law;~~
- ~~(30) Expenses for services for which You would not legally have to pay if there were no insurance;~~
- ~~(31) Services not completed on or before the date of termination;~~
- ~~(32) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;~~
- ~~(33) Any service or procedure not commonly found within the scope of practice by a licensed dentist. Such procedures are identified within the current Common Dental Terminology (CDT Codes) published by the American Dental Association;-~~
- ~~(34) Expenses incurred for services covered on a pediatric only dental plan;~~

## **PART 45 - DEFINITIONS**

**Annual:** The twelve (12) month period beginning on the effective date of the Certificate and ending on the termination date of the Certificate. The Annual time frame will be applied to the Deductible and the Annual Maximum amount.

**Annual Deductible:** The amount each Insured must satisfy before Benefits are payable by Us. To satisfy the Annual Deductible, the Insured must accumulate expenses for Covered Services equal to the Deductible amount shown on the Schedule of Benefits.

**Annual Maximum:** The maximum amount BEST Life will reimburse for covered services during a twelve (12) month period for each Insured person. Once the full Annual Maximum amount has been paid, no additional services will be reimbursed for the remainder of that year. The

~~**Certificate Effective Date:** The date shown on the Statement of Coverage as the Certificate Effective Date.~~

~~**Child:** A person under the age of twenty-six (26) years. Depending on the Child's age, an enrolled Child may be covered either on the Pediatric Dental Plan or Supplemental Dental Plan as follows:~~

- ~~1. A Child who is less than nineteen (19) years of age on the coverage effective date will be covered on the Pediatric Dental Plan until that Child is nineteen (19) years of age on the renewal date;~~
- ~~2. A Child who is between nineteen (19) and twenty-six (26) years of age on the coverage effective date will be covered on the Supplemental Dental Plan until that Child no longer meets the definition of an Eligible Dependent.~~

**Coinurance:** The amount of an expense for a Covered Service that we will pay once the deductible is satisfied.

**Covered Service:** A service or supply listed as a Covered Service and not otherwise limited or excluded by this Certificate. A Covered Service must be provided by a doctor of medical dentistry or a doctor of dental surgery, or a denturist.

**Eligible Dependent:** Means:

- (1) Your lawful spouse or domestic partner and
- (2) Your or Your spouse's or domestic partner's child or children, including a natural child, step-child, foster child, lawfully adopted child or child in the process of being adopted, from the date of placement, or any child for whom You have been granted legal custody, provided they are [less than][between 20 and] 26 years of age; or
- (3) A child named in a Qualified Medical Child Support Order will be considered a dependent.

"Eligible Dependent" also means a dependent child, who upon reaching the termination age, is unable to sustain employment because of a permanent mental or physical handicap and You notify Us in writing within thirty-one (31) days after the termination age, the child will continue to qualify as a dependent under this plan, provided You and the dependent child continue to be insured under this plan, and the child continues to be handicapped and dependent upon You for support. This shall not apply to a dependent child who is beyond the termination age on the date You become eligible for dependent insurance under this Policy.

**Family Deductible:** The Family Deductible is satisfied when each of three (3) covered members of Your family satisfy the Annual Deductible. Once the combined costs of services provided by covered members of Your family is equal to the Family Deductible amount, no additional Deductible will be required for other insured family members for the remainder of the Calendar Year.

**Emergency Care:** A dental emergency where an acute disorder of oral health requires dental and/or medical attention, including broken, loose, or evulsed teeth caused by traumas; infections and inflammations of the soft tissues of the mouth; and complications of oral surgery, such as dry tooth socket.

**Grace Period:** A Grace Period of thirty-one (31) days from the due date will be allowed for payment of each premium after the first. This coverage will remain in effect during the Grace Period; provided the premium is paid before the end of the Grace Period.



**Insured:** The Subscriber or any Eligible Dependent of a Subscriber who is enrolled in and covered under the Policy.

**Medically Necessary:** The determination process that may include, and not limited to, the evaluation of the effectiveness and benefit of a dental service or supply for the individual patient based on scientific evidence considerations, up-to-date and consistent professional standards of care, convincing expert opinion and a comparison to alternative interventions, including interventions, and the cost effectiveness of such service or supply. Medical necessity may be obtained by applying an Advance Notice of Treatment.

**Network Provider:** A dental care professional that is contracted with Us and is part of the Network shown on the Schedule of Benefits.

**Out-of-Network Provider:** A dental care professional that is not a Network Provider.

**Policy Effective Date:** The date shown on the Statement of Coverage as the Policy Effective Date.

~~**Plan:** Means any Plan providing benefits or services for or by reason of dental or treatment, which benefits or services are provided in: (1) group, blanket or franchise insurance coverage; (2) group practice and other group prepayment coverage; (3) group service Plans; (4) any coverage under labor management trustee Plans, union welfare Plans, Employer organization Plans or Employee benefit organization Plans; and (5) any coverage under governmental programs, and any coverage required or provided by any statute. For purposes of coordinating benefits under this Policy, the term "Plan" shall not include any plan of individual coverage or school or church accident type coverages.~~

~~The term "Plan" shall be construed separately with respect to each Policy, contract or other arrangement for benefits or services and separately with respect to that portion of such Policy, contract or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.~~

**Statement of Coverage:** The proof of insurance issued to an individual insured under the Policy, outlining the insurance benefits and principle provisions applicable to the member.

**Subscriber:** The primary insured person as shown on the Statement of Coverage.

**Usual, Reasonable and Customary:** The charge for health care that is consistent with the average rate or charge for identical or similar services in a certain geographical area.

**You or Your:** Means the Insured.

## **PART 56 - COVERAGE EFFECTIVE AND TERMINATION DATES**

### **EFFECTIVE DATE**

**Coverage:** The Insured's coverage will take effect on the Insured's Effective Date as shown on the Statement of Coverage.

### **TERMINATION OF INSURANCE**



The Insured's coverage will stop on the earliest of the following dates:

- (1) the last day of the month in which the Subscriber stops being a member of the Association;
- (2) the last day of the month in which the Insured stops being a member of a class eligible for insurance under this plan;
- (3) the last day of the month in which the Subscriber requests coverage be cancelled;
- (4) the day before the due date of any premium that remains unpaid at the end of the Grace Period;
- (5) the date the Policy terminates;
- (6) the last day of the month in which an Insured stops meeting the definition of Eligible Dependent; or
- (7) the day the Insured moves outside of the service area for Insured's selected network. Insured may request a plan change if Insured moves within an area where an alternate plan is available.

BEST Life will notify Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of this insurance coverage.

## **~~PART 7—COORDINATION OF BENEFITS~~**

~~**Benefits Subject to this Provision:** All of the benefits provided under the Policy are subject to this provision.~~

~~If an Insured is covered by two or more group health insurance policies, the policies may coordinate benefits. Group insurance was designed to cover dental expenses; however, it was never intended to pay in excess of 100% of incurred charges. Coordination of Benefits is established as a method by which two or more carriers or plans could coordinate their respective benefits so the total benefit paid does not exceed 100% of the total allowable expenses incurred.~~

~~When there are two or more group carriers involved, one of the carriers is primary and one is secondary. This continues for all carriers involved. The primary carrier pays first, the secondary carrier pays second. This continues for all carriers involved. The order of the carriers is determined, as follows:~~

~~**Dependent Children of Non-Separated or Divorced Parents:** The plan covering the parent whose birthday falls earlier in the year is the primary carrier for an Insured under this Certificate. If both parents have the same birthday, the plan that has provided coverage longer is the primary carrier.~~

~~**Dependent Children of Separated or Divorced Parents:** The plans must pay in the following order:~~

- ~~• First, the plan of the parent with custody of the child;~~
- ~~• Then, the plan of the spouse or domestic partner of the parent with custody of the child;~~
- ~~• Finally, the plan of the parent not having custody of the child.~~

~~However, if terms of a court decree state that one parent is responsible for the health care expenses of the child, and the insurance company has been advised of the responsibility, that plan is primary carrier over the plan of the other parent.~~

~~**Dependent Children of Parents With Joint Custody:** The birthday rule applies in this situation.~~

~~**Right to Receive and Release Necessary Information:** For the purpose of determining the applicability of and implementing the terms of this provision of this Plan or any provisions of similar purpose of any other Plan, We may, with the consent of any person, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which We deem to be~~

~~necessary for such purposes. Such information may include information for payment of claims, information to administer your benefits or information to determine medical necessity with our case manager. Any person claiming benefits under this Plan shall furnish to Us such information as may be necessary to implement this provision.~~

~~**Facility of Payment:** Whenever payments which should have been made under this Plan in accordance with the Policy have been made under any other Plans, We shall have the right to pay over to any organizations making such other payments any amounts to satisfy our obligation under the Policy, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, We shall be fully discharged from liability under this Plan.~~

~~**Right to Recovery:** Whenever payments have been made by Us with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, We shall have the right to recover such payments, to the extent of such excess, from among one or more of the following: any persons to or for or with respect to whom such payments are made, any other insurers, service Plans or any other organizations.~~

## **PART 68 – PREMIUM PROVISIONS**

**Premium Payments:** Renewal premiums are payable to the Company. The payment of any premium shall not continue this Policy in force beyond the next premium due date, except as provided in the Grace Period provision.

**Changes in Premiums:** We may change the amount of the required premium due from the Policyholder by giving the Policyholder at least sixty (60) days advance written notice. During the first 12 months, We will not change the amount of the required premium.

**Grace Period:** This Policy has a thirty-one (31) day Grace Period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following thirty-one (31) days. During the Grace Period, this Policy will remain in force. If the required premium is not paid by the end of this Grace Period, this Policy will lapse as of the end of the Grace Period.

**Termination of Policy:** We may terminate this Policy at any time following the first renewal date by giving the Policyholder written notice at least sixty (60) days in advance. The Policyholder may also terminate this Policy by giving Us written notice at least sixty (60) days before the intended termination date. This Policy will also terminate if the required premium is not paid by the Policyholder as provided in the Grace Period provision.

**Reinstatement:** If any renewal premium is not paid by the end of the Grace Period, coverage under this Policy will be terminated. However, BEST Life will reinstate this Policy, without requiring an application for reinstatement, as long as premium is paid for at least the sixty (60) days prior to the date of reinstatement. The reinstated Policy will cover only loss resulting from an accidental injury sustained after the date of reinstatement and loss due to sickness beginning ten (10) days after reinstatement. In all other respects the insured and BEST Life shall have the same rights as they had under the Policy immediately before the due date of the defaulted premium, subject to conditions and provisions of the Policy.

## **PART 97 – GENERAL PROVISIONS**

**Clerical Error:** Clerical error by the Policyholder shall not invalidate insurance otherwise validly in force nor continue insurance otherwise validly terminated.

**Third Party Responsibility:** If an Insured is injured or becomes ill through the act or omission of another person, to the extent that the Insured recovers medical expenses for the same Injury or Illness from a third party or its insurer, We will be entitled to a repayment of any remuneration in excess of benefits paid under the Policy due to the same Injury or Illness, and after the Insured is fully compensated for his or her loss. We may file a lien for such repayment. Upon request, the Insured must complete and return the required forms to Us.

The repayment agreement will be binding upon the Insured, or the legal representative of a minor or incompetent, whether:

- (1) the payment received from the third party, or its insurer, is the result of:
  - legal judgment;
  - an arbitration award;
  - a compromise settlement;
  - any other arrangements; or
- (2) the third party or its insurer had admitted liability for the payment; or
- (3) the medical expenses are itemized in the third party payment.

**Entire Contract; Changes:** The Policy, including the endorsements, certificates, riders, application and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions. We will consider any statement made by the Insured or the Policyholder, in the absence of fraud, as a representation and not a warranty.

**Underwriting Decisions:** If, for any reason, We cannot accept Your application for coverage, We will communicate Our decision to You in writing with the reasons supporting Our decision.

**Notification to Insureds:** BEST Life will notify Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of your insurance, a change in your premium, a change in eligibility or a change in your benefits. ~~This notice will be given to the appropriate insurance producer and the appropriate administrator, if any, along with non-employee certificate holders.~~

**Right to Contest:** After this Policy has been in force for a period of two (2) years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application. No claim for loss incurred or disability (as defined in the Policy) commencing after two (2) years from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Policy.

**Notice of Claim:** We must receive written notice within twenty (20) days after a claim starts or as soon as reasonably possible. The notice shall be sent to BEST Life and Health Insurance Company at [2505 McCabe Way, Irvine, California 92614] or given it to Our agent.

**Claim Forms:** When We receive a notice of claim, We will send forms for filing the claim. If the Subscriber or Insured do not receive these forms within fifteen (15) days, the Subscriber or Insured may send Us a written statement to satisfy this requirement. This statement should include the nature and extent of the claim and be sent to Us within the time stated in the Proof of Loss provision.

**Proof of Loss:** We must receive written proof of loss within ninety (90) days of a claim. If it is not possible for proof to be provided within the ninety (90) days, We will not deny a claim for this reason if We receive the proof as soon as possible. In any event, We must receive proof no later than one year from the time specified, unless Subscriber is legally incapacitated.

**Time of Payment of Claims:** Indemnities payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this Policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

**Payment of Claims:** All payments will be made to Subscriber or Insured's provider.

**Legal Actions:** A legal action may not be brought against Us before sixty (60) days, or after three (3) years, from the date written proof of loss is required to be given.

**Time Limit on Certain Defenses:** After this Policy has been in force for two (2) years, We will not use any statements made in the application of the Policyholder to void the Policy. After an Insured Person has been covered under this Policy for two (2) years, We will not use any statement made in the Insured Person's enrollment form to defend a claim.

**Misstatement of Age:** If the age of any individual covered under the Policy has been misstated, there shall be an adjustment of premium for the Policy so that there shall be paid to Us the premium for the coverage of such individual at his or her correct age, and the amount of the insurance coverage shall not be affected.

**Worker's Compensation:** The Policy is not in lieu of and does not affect any requirement for coverage by Worker's Compensation Insurance.

**Conformity with State Statutes:** Any provisions of the Policy which are in conflict with the statutes of the state in which the Policy was issued or delivered will be changed to conform to such laws.

**Waiver of Rights:** If We fail to enforce any provision of the Policy, such failure will not affect Our right to do so at a later date, nor will it affect Our right to enforce any other provision of the Policy.

**Inspection of Policy:** The Policy is in the possession of the Policyholder. It may be inspected at any time during business hours at the office of the Policyholder.

**Duty to Cooperate:** As a condition precedent to the payment of benefits hereunder, the Subscriber and Insured are required to cooperate with Us by providing all information reasonably required to accurately process a claim. Any failure to provide necessary information may result in a denial of benefits for the claim.

## **PART 810 – FILING A DENTAL CLAIM**

**HOW TO FILE A CLAIM:** Claim forms may be obtained from [the BEST Life website located at [www.bestlife.com](http://www.bestlife.com), click on "Forms"].

Submit claims to [BEST Life and Health Insurance Company], [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

For questions about a claim payment, contact BEST Life's Customer Service at [1-800-433-0088 or at [cs@bestlife.com](mailto:cs@bestlife.com), Monday through Friday, 7 am to 5 pm Pacific Time].

**CLAIMS DENIAL PROCEDURE:** Any denial of a claim for Benefits will be explained in writing. The explanation will include (a) the specific reason for the denial, (b) reference to the plan provision upon which the denial was based, (c) a description of any additional information that might be required to provide and an explanation of why it is needed, and (d) an explanation of the plan's claim review procedure.

**APPEALING THE DENIAL OF A CLAIM:** You or an authorized representative You appoint to assist or represent You, may appeal any denial of a claim, in whole or in part, for Benefits by filing a written request for a review. The request must include all reasons You believe the initial decision was incorrect and all documentation supporting Your appeal, to BEST Life and Health Insurance Company, Attn: Appeals, [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

A request for a review must be filed within one-hundred and eighty (180) days after the date on which we issue the written notice of denial of a claim. BEST Life and Health Insurance Company will provide an appeal determination not later than sixty (60) days after receipt of a request for review. If there are special circumstances, the decision will be made as soon as possible, but no later than fifteen (15) days after receipt of the request for review. The appeal determination will be in writing and will include specific reasons for the decision. This decision shall also include specific references to the Policy provisions on which the decision was based.

**Underwritten by BEST Life and Health Insurance Company**

# Individual Insurance Policy

## Dental PPO Plan



[2505 McCabe Way  
Irvine, California 92614]

**Notice to Buyer: This Policy provides dental coverage only.**

**BEST Life and Health Insurance Company**  
[2505 McCabe Way  
Irvine, California 92614]

A STOCK COMPANY  
(Herein called the Company)

**BEST Life and Health Insurance Company ("BEST Life")** is issuing this Policy in consideration of the accuracy of representations made in Your application and Your payment of premiums for Policy coverage.

**READ YOUR POLICY CAREFULLY:** This Policy is a legal contract between You (owner of this Policy) and Us.

**GOVERNING JURISDICTION:** The Policy is issued in the State of Tennessee. It shall be construed in accordance with the laws of the issuing State.

**NOTICE OF TEN DAY RIGHT TO EXAMINE:** We want You to fully understand and be satisfied with the insurance coverage. If for any reason You are not satisfied, You may return this Policy to Your agent or to Our home office within ten (10) days of receipt and Your premium will be fully refunded. Coverage will then be void retroactive to the Insurance Effective Date.

**RENEWAL AND PREMIUM PAYMENT PROVISIONS:** You may renew this Policy for additional coverage periods by paying the premium when due or within the Grace Period until the Insureds reach age [19][65]. Each period of coverage runs from premium due date to premium due date. We reserve the right to change premiums. Any such change will be made according to the table of premium rates that will apply to all policies with the same form and class in Your State. All future renewal premiums will be based on Your original issue age. We will notify You of any premium rate increase at least sixty (60) days in advance. We cannot cancel this Policy while it is in force.

**IN WITNESS WHEREOF,** We have caused this Policy to be signed by Our President and Our Secretary. This Policy takes effect at 12:01 a.m. at Your residence on its Effective Date. This Policy terminates at 12:01 a.m. on the date any renewal premium is due and not paid, subject to the Grace Period.

[



**President**

II



**Secretary**

**Group PPO  
Pediatric Dental Policy  
Non-Participating**



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## PART 1 - SCHEDULE OF BENEFITS

This Policy is made valid on the effective dates shown for the listed Insureds on the Statement of Coverage.

Covered Services received by Insured from a Network Provider are reimbursed at the Network Provider's contracted Fee Schedule. Covered Services received by Insured from an Out-of-Network Provider are reimbursed at the [80th or 90th] percentile of a Usual, Reasonable and Customary schedule. All Covered Services are subject to Cost Sharing as shown on this Schedule of Benefits.

### [Pediatric Dental Plan Schedule of Benefits For Children to Age 19]

	<b>[BEST Life Child Dental] [Plus] Pediatric Dental Plan</b>	
<b>Procedure Categories</b>	<b>In-Network [Network Name]</b>	<b>Out-of-Network</b>
<b>Out-of-Pocket Maximum</b>	\$700 for 1 Child \$1,400 for 2 or more Children	\$700 for 1 Child \$1,400 for 2 or more Children
<b>Annual Deductible</b> – Applies to Preventive[,] [services received Out-of-Network as well as] Basic and Major services received In-Network or Out-of-Network	\$[0][50]	\$[50][100]
<b>Diagnostic &amp; Preventive Services Coinsurance</b> – Exams, cleanings, sealants, fluoride treatment, x-rays	100%	[90][60]%
<b>Basic Services Coinsurance</b> – Fillings	[70][55]%	[60][40]%
<b>Major Services Coinsurance</b> – Crowns & casts, prosthodontics, endodontics, periodontics, oral surgery	[50][35]%	[40][20]%
<b>Orthodontic Services Coinsurance</b> (Medically necessary Orthodontic Services only)	50% [24 Month Wait]	50% [24 Month Wait]

**[Dental Plan Schedule of Benefits  
For Adults and Dependent Children between 19 and 26]**

	<b>[BESTOne Dental] [Advantage][Plus][Basic] Supplemental Plan</b>	
<b>Benefits Description</b>	<b>In-Network [Network]</b>	<b>Out-of-Network</b>
<b>Annual Maximum</b>	\$[500 – 3,500]	
<b>Annual Deductible</b> (Applies to Basic and Major) – 3 Deductible Maximum per Family	[\$0-100]	
<b>Preventive Care Services</b> Routine oral exam, cleanings, X-rays	[100-70]%	[100-70]%
<b>Basic Services</b> Fillings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology	[90-50]%	[80-20]%
<b>Major Services</b> Crowns & gold fillings, inlays, onlays & pontics, [implants,] fixed bridges, complete & partial dentures	[60-0]%	[50-0]%
<b>[Major Services Waiting Period]</b>	12 Months]	
<b>Endodontic Services</b>	[Basic][Major]	
<b>Periodontic Services</b>	[Basic][Major]	
<b>Oral Surgery Services</b>	[Basic][Major]	
<b>Usual and Customary Reimbursement</b>	Fee Schedule	[80 <sup>th</sup> ][90 <sup>th</sup> ] Percentile

**PART 2 - BENEFITS AND EXCLUSIONS**

**COVERED SERVICES ON  
PEDIATRIC DENTAL PLAN**

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Policy.

**Class I – Preventive and Diagnostic Procedures Include:**

- (1) Prophylaxis not more often than once every six (6) months;
- (2) Topical application of fluoride (excluding prophylaxis) not more often than twice every twelve (12) months;
- (3) Topical fluoride varnish not more often than twice every twelve (12) months;
- (4) Sealants not more often than once per tooth in a thirty-six (36) month period and limited to unrestored permanent molars for individuals under age nineteen (19);
- (5) Space maintainers, including re-cementation, for individuals under age nineteen (19) (excluding removal of fixed space maintainer);
- (6) Periodic oral evaluation not more often than once every six (6) months;
- (7) Limited oral evaluation (problem focused) not more often than once every six (6) months;
- (8) Comprehensive oral evaluation not more often than once every six (6) months;
- (9) Comprehensive periodontal evaluation not more often than once every six (6) months;
- (10) Intraoral complete X-rays or panoramic film not more often than once in a 60-month period;
- (11) Bitewing X-rays not more often than one set every six (6) months;
- (12) Single film intraoral periapical or occlusal;

- (13) Palliative treatment of dental pain (minor procedure);

**Class II – Basic Procedures Include:**

- (1) Amalgams, resin-based composites, re-cement inlays, re-cement crowns, protective restoration, pin retention;
- (2) Prefabricated stainless steel crowns not more often than once per tooth in a sixty (60) month period for individuals under age fifteen (15);
- (3) Therapeutic pulpotomy (excluding restoration) if a root canal is not performed within forty-five (45) days of the pulpotomy;
- (4) Partial pulpotomy for apexogenesis limited to permanent tooth with incomplete root development, if a root canal is not performed within forty-five (45) days of pulpotomy;
- (5) Pulpal therapy (excluding final restoration) once per tooth per lifetime, limited to primary incisor teeth for individuals up to age six (6), and limited to primary molars and cuspids for individuals up to age eleven (11);
- (6) Periodontal scaling and root planning, per quadrant, not more often than once every twenty-four (24) months;
- (7) Periodontal maintenance not more often than four in a twelve (12)-month period, combined with adult prophylaxis after the completion of active periodontal therapy;
- (8) Adjustment and repair of complete or partial dentures;
- (9) Rebase and reline not more often than once in a thirty-six (36) month period, six (6) months after initial installation;
- (10) Tissue conditioning;
- (11) Recement fixed partial denture
- (12) Fixed partial denture repair, by report;
- (13) Oral surgery:
  - a. extraction for erupted tooth or exposed root;
  - b. surgical removal of erupted tooth;
  - c. removal of impacted tooth;
  - d. removal of residual tooth roots;
  - e. coronectomy;
  - f. tooth reimplantation;
  - g. surgical access of unerupted tooth;
  - h. alveoloplasty;
  - i. removal of exostosis;
  - j. incision and drainage of abscess;
  - k. suture of recent small wounds up to five (5) cm
  - l. excision of pericoronal gingival;

**Class III – Major Procedures Include:**

- (1) Detailed and extensive oral evaluation;
- (2) Inlays, onlays, crowns, core buildup, including any pins, prefabricated post and core in addition to crown, limited to one per tooth every sixty (60) months;
- (3) Endodontics (root canal)
- (4) Gingivectomy or gingivoplasty, four (4) or more teeth not more often than once every thirty-six (36) months;
- (5) Gingival flap procedure, four (4) or more teeth not more often than once every thirty-six (36) months;
- (6) Osseous surgery, four (4) or more contiguous teeth or bounded teeth spaces per quadrant, not more often than once every thirty-six (36) months;
- (7) Full mouth debridement limited to one (1) per lifetime;

- (8) Complete and partial dentures, including abutments, pontics, onlays, retainers and crowns, not more often than once every sixty (60) months (excludes interim dentures);
- (9) Implants and implant services once every sixty (60) months only if medically necessary;
- (10) Occlusal guard not more often than once in twelve (12) months for individuals thirteen (13) and older with predetermination only;
- (11) General anesthesia or IV sedation;
- (12) Consultation by dentist or physician other than the dentist providing treatment;
- (13) Therapeutic drug injection with predetermination;
- (14) Treatment of post-surgical complications with predetermination.

[**Note:** Unless the twenty-four (24) month waiting period requirement for Medically Necessary Orthodontic services has been met, the services below are not covered benefits for any treatment that began during the twenty-four (24) month period immediately following Your effective date of coverage.]

**Class IV – Medically Necessary Orthodontic Procedures Include:**

- (1) For orthodontia services associated with the repair of cleft palate and palate or other severe craniofacial defects or injury for which the function of speech, swallowing or chewing is restored;
- (2) Requires predetermination; and
- (3) Coverage includes diagnosis, treatment plan, anticipated treatment time and cost estimate.

**EXCLUSIONS ON  
PEDIATRIC DENTAL PLAN**

The following exclusions are not Covered Services. No payments will be made by Us for these services:

- (1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;
- (2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
- (3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
- (4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;
- (5) Services and supplies started and not completed before the patient was covered under this Plan, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
- (6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
- (7) Space maintainers;
- (8) Sealants if re-sealed within a five (5) year period;
- (9) Retreatment of a previous root canal or apicoectomy/periradicular surgery;
- (10) Elective tooth extractions;
- (11) Separate payments for open and drain palliative procedure when the root canal is completed on the same date of service;
- (12) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are defined as a Covered Dental Expense;
- (13) Charges in excess of Usual, Reasonable and Customary charges amount stated in the "Schedule

- of Benefits" section of this Plan, or in excess of the Preferred Provider Fee Schedule;
- (14) Charges for service provided for temporomandibular joint dysfunction (TMJ);
  - (15) Expenses incurred for congenital or developmental malformations, except as defined as a Covered Orthodontic Expense;
  - (16) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits, except as defined as a Covered Orthodontic Expense;
  - (17) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
  - (18) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, the patient's lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;
  - (19) Expenses for services for which the patient would not legally have to pay if there were no insurance, unless mandated by the State;
  - (20) Services not completed on or before the date of termination;
  - (21) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
  - (22) Expenses that are applied toward satisfaction of a Deductible, if any;
  - (23) Any service or procedure not commonly found within the scope of practice by a licensed dentist;
  - (24) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
  - (25) Chemotherapeutic agents and any other experimental procedures;
  - (26) Expenses incurred for veneers and related procedures;
  - (27) Services and supplies performed outside of the United States of America.

#### **[COVERED SERVICES ON SUPPLEMENTAL DENTAL PLAN**

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Policy.

##### **CLASS I - Preventive Dental Procedures include:**

- (1) Routine oral examination and diagnosis not more often than twice every twelve (12) months per individual;
- (2) Bitewing x-rays not more often than once every twelve (12) months per individual;
- (3) Full mouth x-rays or panoramic films are limited to once every five (5) years; any combination of eight (8) or more x-rays (including but not limited to bitewings or periapicals/intraorals) will be combined into a full mouth x-ray series;
- (4) Prophylaxis not more often than once every six (6) months per individual.

##### **CLASS II - Basic Dental Procedures include:**

- (1) Pathology;
- (2) All fillings other than lab fabricated restorations (composite fillings limited to permanent anterior and posterior teeth);
- (3) Emergency palliative treatment;
- (4) Limited oral exam not more than once every six months;
- (5) Simple extraction, excluding orthodontic extractions unless a orthodontic benefits are a Covered Dental Expense on this Plan;



- (6) Surgical extraction, including impaction:
  - (a) erupted tooth;
  - (b) soft tissue impaction;
  - (c) partial bony impaction;
  - (d) complete bony impaction;
- (7) General anesthesia or intravenous sedation when required for complex oral surgical procedures (partial and complete bony impacted extractions only);
- (8) Periodontics (tissues and gums);
- (9) Periodontal exam (not in addition to a routine oral exam);
- (10) Periodontal maintenance (limited to once every six (6) months per individual following active periodontal treatment) and not on the same visit as a routine prophylaxis;
- (11) Periodontal scaling and root planing (limited to once every 36 months and to two (2) quadrants per visit, and not in addition to a routine prophylaxis);
- (12) Endodontics (pulp capping and root canal); and
- (13) Oral surgery:
  - (a) root recovery (surgical removal of residual root);
  - (b) oral antral fistula closure;
  - (c) removal of a dentigerous or odontogenic cyst;
  - (d) incision and drainage of an abscess;
  - (e) removal of lateral exostosis;
  - (f) frenulectomy.

[**Note:** Unless the twelve (12) month waiting period requirement for Major Dentistry services has been met, the services below are not covered benefits for any treatment that began during the twelve (12) month period immediately following Your effective date of coverage.]

**CLASS III - Major Dental Procedures include:**

- (1) Inlays, onlays, crowns and other lab fabricated restorations (not including veneers);
- (2) Porcelain, porcelain fused to metal, or full gold crowns on permanent teeth;
- (3) Full or partial dentures or fixed bridgework or adding teeth to an existing denture, if required because of loss of functional natural teeth while the person is covered for this Benefit. The work must be done within twelve (12) months after the extraction and while this coverage is in force;
- (4) Replacement or alteration of full or partial dentures or fixed bridgework caused by the following while coverage is in force:
  - (a) accidental injury requiring oral surgical treatment, or
  - (b) oral surgical treatment involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus or redundant tissue, provided the replacement or alteration is done within twelve (12) months of the injury or surgical treatment.
- (5) Replacement of a full denture or bridgework if the replacement is made more than seven (7) years after the date of installation, unless:
  - (a) such replacement is made necessary by the initial extraction of an adjoining functional natural tooth; or
  - (b) the prosthesis, while in the oral cavity, has been damaged beyond repair as a result of a non-chewing injury while covered;
- (6) Repair or reline of dentures and bridgework[;
- (7) Implants, as an alternative to a fixed prosthetic, (limited to once in a lifetime per site). The cost of the fixed prosthetic will be applied to the total value of the implant and implant-related procedures, not to exceed the cost of the fixed prosthetic:
  - (a) the surgical placement of endosteal implant body including healing cap, where the bone and soft tissues are sound and healthy;
  - (b) implant supported prosthetics;

- (c) eposteal and transosteal implants will be covered at the cost of the endosteal implant (if performed, member is responsible for additional fees);
- (d) bone grafting and tooth extractions, provided the work is done while this coverage is in force;
- (e) implant maintenance].

### **EXCLUSIONS ON SUPPLEMENTAL DENTAL PLAN**

The following exclusions are not Covered Services. No payments will be made by Us for these services:

- (1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;
- (2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
- (3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
- (4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;
- (5) Services and supplies begun and not completed prior to the patient's effective date, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
- (6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
- (7) Pulp capping, if in conjunction with the installation of inlays, onlays or crowns and fillings or other lab fabricated restorations; including but not limited to inlays, onlays and crowns, preventative tests and examinations diagnostic casts and oral cancer screenings, and expenses incurred for sedative fillings, including charges for prescribed drugs, pre-medication or analgesia;
- (8) The initial installation of a prosthetic device (a fixed bridge, implant, or denture), including crowns and inlays which form abutments, to replace teeth missing before You were covered under the Policy, except when it also replaces a tooth that is extracted while covered unless such installation commences after You have remained continuously covered under this plan for at least three years immediately prior to the date such installation commences;
- (9) Implants, implant services and implant supported prosthetics[ are not covered for patients under the age of sixteen (16)];
- (10) Expenses incurred for veneers and related procedures;
- (11) Replacement of a lost or stolen or discarded prosthetic device;
- (12) Adjustment, repairs or relines of prostheses for a period of one (1) year from initial placement if the prostheses were paid for under this plan;
- (13) Expenses incurred for a core buildup will only be considered in conjunction with a crown;
- (14) If multiple endodontic treatments are necessary on the same tooth within a period of one (1) year, the allowance will be made for only one (1) procedure;
- (15) X-rays are considered an integral part of the endodontic procedure rather than a separate service and are therefore not eligible for benefits;
- (16) The extraction of immature erupting third molars and non-pathologic, asymptomatic third molar extractions;
- (17) Expenses for gross debridement allowed one time at the beginning of the periodontal treatment plan prior to pocket depth charting;

- (18) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
- (19) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are a Covered Dental Expense on this Plan;
- (20) Surgical procedures incidental to orthodontic treatment, including but not limited to, extraction of teeth solely for orthodontic reasons, exposure of impacted teeth, correction of micrognathia or macrognathia, or repair of cleft palate;
- (21) Charges for service provided for temporomandibular joint dysfunction (TMJ);
- (22) Expenses incurred for congenital or developmental malformations;
- (23) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
- (24) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits;
- (25) Chemotherapeutic agents and any other experimental procedures;
- (26) Charges in excess of Usual, Reasonable and Customary charges or in excess of the Calendar Year Maximum amount stated in the "Schedule of Dental Benefits" section of this Plan, or in excess of the Preferred Provider Fee Schedule;
- (27) Expenses that are applied toward satisfaction of a Deductible, if any;
- (28) Services and supplies performed outside of the United States of America;
- (29) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, Your lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;
- (30) Expenses for services for which You would not legally have to pay if there were no insurance;
- (31) Services not completed on or before the date of termination;
- (32) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
- (33) Any service or procedure not commonly found within the scope of practice by a licensed dentist. Such procedures are identified within the current Common Dental Terminology (CDT Codes) published by the American Dental Association;
- (34) Expenses incurred for services covered on a pediatric only dental plan.]

### **PART 3 - LIMITATIONS AND COST SHARING**

#### **ACCESS TO CARE**

##### **Using a Network Provider:**

BEST Life offers Insureds the option to save on out-of-pocket costs when care is provided by a Network Provider. A listing of General Dentists and Specialists is available. To find a Network Provider, please refer to the Network information provided on the ID Card.

##### **How to Select a Dentist:**

Insureds on this Plan may obtain dental services from any licensed dental professional in the United States. To use the Plan, Insureds may directly contact the dentist of their choice and make an appointment. Insureds are advised to bring their ID Card to their appointment. The dentist may require a copy of the Insured's ID Card to confirm eligibility on this Plan.

##### **How to Obtain a Referral:**

A dentist may determine that an Insured requires treatment from a dental provider that specializes in a type of dentistry (Specialist). The Insured does not need to contact BEST Life for a referral. The Insured can directly contact the Specialist to make an appointment. The Specialist may require

information from the Insured's dentist to determine a treatment plan and may contact the dentist directly.

### **ADVANCE NOTICE OF DENTAL TREATMENT**

Subscriber or Insured should submit Advance Notice of Dental Treatment before treatment commences in order to obtain Predetermination of Covered Services, including services that are medically necessary. If dental services are performed without such Predetermination, We reserve the right to deny any claim submitted with respect to such Covered Services; provided however, that predetermination is not required for:

- (1) Covered Services for which the related expense is less than \$500 during any course of treatment ("course of treatment" means one treatment or one of a planned series of treatments resulting from dental examination);
- (2) Emergency treatment; or
- (3) Oral examination and prophylaxis.

Predetermination is required for the following dental services for children:

- (1) Medically necessary services or supplies;
- (2) Panoramic film for children under age six (6);
- (3) Periodontal scaling and root planing;
- (4) Occlusal orthotic devices;
- (5) Appliance therapy;
- (6) Orthodontia, including preorthodontic treatment visit.

Predetermination is required for the following dental services for adults and children 19 or older:

- (1) Crowns, Anterior, except with posts or root canal;
- (2) Crowns, 2 or more Posterior, except with posts or root canal;
- (3) Inlays or Onlays, 2 or more, except with posts or root canal;
- (4) Laminates;
- (5) Anterior composites;
- (6) 2 or more multiple surfaces;
- (7) Bridges – initial or replacement;
- (8) Eligible partial dentures – initial or replacement;
- (9) Periodontal surgery over \$500;
- (10) Full bony impactions, 2 or more.

We will have thirty (30) days to furnish the provider with an Explanation of Benefits demonstrating whether the proposed treatment will be a Covered Service under this Policy.

### **DEDUCTIBLES**

**Annual Deductible:** The Annual Deductible shown in the Schedule of Dental Benefits will apply separately to each Insured. Each Insured must accumulate eligible expenses equal to the deductible amount.

### **ALTERNATIVE PROCEDURES**

If more than one treatment plan exists for a dental procedure, covered dental expenses will be based on

the least expensive procedure that will produce a result that meets professionally recognized standards. If the Insured's provider elects the more expensive treatment, the Insured or Subscriber shall be responsible for any charges that are greater than the covered expense for the less expensive treatment.

#### **PART 4 - DEFINITIONS**

**Annual:** The twelve (12) month period beginning on the effective date of the Certificate and ending on the termination date of the Certificate. The Annual time frame will be applied to the Deductible and the Annual Maximum amount.

**Annual Deductible:** The amount each Insured must satisfy before Benefits are payable by Us. To satisfy the Annual Deductible, the Insured must accumulate expenses for Covered Services equal to the Deductible amount shown on the Schedule of Benefits.

**Annual Maximum:** The maximum amount BEST Life will reimburse for covered services during a twelve (12) month period for each Insured person. Once the full Annual Maximum amount has been paid, no additional services will be reimbursed for the remainder of that year. The

**Child:** A person under the age of twenty-six (26) years. Depending on the Child's age, an enrolled Child may be covered either on the Pediatric Dental Plan or Supplemental Dental Plan as follows:

1. A Child who is less than nineteen (19) years of age on the coverage effective date will be covered on the Pediatric Dental Plan until that Child is nineteen (19) years of age on the renewal date;
2. A Child who is between nineteen (19) and twenty-six (26) years of age on the coverage effective date will be covered on the Supplemental Dental Plan until that Child no longer meets the definition of an Eligible Dependent.

**Coinsurance:** The amount of an expense for a Covered Service that we will pay once the deductible is satisfied.

**Covered Service:** A service or supply listed as a Covered Service and not otherwise limited or excluded by this Certificate. A Covered Service must be provided by a doctor of medical dentistry or a doctor of dental surgery, or a dentist.

**Eligible Dependent:** Means:

- (1) Your lawful spouse or domestic partner and
- (2) Your or Your spouse's or domestic partner's child or children, including a natural child, step-child, foster child, lawfully adopted child or child in the process of being adopted, from the date of placement, or any child for whom You have been granted legal custody, provided they are [less than][between 20 and] 26 years of age; or
- (3) A child named in a Qualified Medical Child Support Order will be considered a dependent.

"Eligible Dependent" also means a dependent child, who upon reaching the termination age, is unable to sustain employment because of a permanent mental or physical handicap and You notify Us in writing within thirty-one (31) days after the termination age, the child will continue to qualify as a dependent under this plan, provided You and the dependent child continue to be insured under this plan, and the child continues to be handicapped and dependent upon You for support. This shall not apply to a dependent child who is beyond the termination age on the date You become eligible for dependent insurance under this Policy.

**Family Deductible:** The Family Deductible is satisfied when each of three (3) covered members of Your family satisfy the Annual Deductible. Once the combined costs of services provided by covered members of Your family is equal to the Family Deductible amount, no additional Deductible will be required for other insured family members for the remainder of the Calendar Year.

**Emergency Care:** A dental emergency where an acute disorder of oral health requires dental and/or medical attention, including broken, loose, or evulsed teeth caused by traumas; infections and inflammations of the soft tissues of the mouth; and complications of oral surgery, such as dry tooth socket.

**Grace Period:** A Grace Period of thirty-one (31) days from the due date will be allowed for payment of each premium after the first. This coverage will remain in effect during the Grace Period; provided the premium is paid before the end of the Grace Period.

**Insured:** The Subscriber or any Eligible Dependent of a Subscriber who is enrolled in and covered under the Policy.

**Medically Necessary:** The determination process that may include, and not limited to, the evaluation of the effectiveness and benefit of a dental service or supply for the individual patient based on scientific evidence considerations, up-to-date and consistent professional standards of care, convincing expert opinion and a comparison to alternative interventions, including interventions, and the cost effectiveness of such service or supply. Medical necessity may be obtained by applying an Advance Notice of Treatment.

**Network Provider:** A dental care professional that is contracted with Us and is part of the Network shown on the Schedule of Benefits.

**Out-of-Network Provider:** A dental care professional that is not a Network Provider.

**Policy Effective Date:** The date shown on the Statement of Coverage as the Policy Effective Date.

**Statement of Coverage:** The proof of insurance issued to an individual insured under the Policy, outlining the insurance benefits and principle provisions applicable to the member.

**Subscriber:** The primary insured person as shown on the Statement of Coverage.

**Usual, Reasonable and Customary:** The charge for health care that is consistent with the average rate or charge for identical or similar services in a certain geographical area.

**You or Your:** Means the Insured.

## **PART 5 - COVERAGE EFFECTIVE AND TERMINATION DATES**

### **EFFECTIVE DATE**

**Coverage:** The Insured's coverage will take effect on the Insured's Effective Date as shown on the Statement of Coverage.

### **TERMINATION OF INSURANCE**

The Insured's coverage will stop on the earliest of the following dates:

- (1) the last day of the month in which the Subscriber stops being a member of the Association;
- (2) the last day of the month in which the Insured stops being a member of a class eligible for insurance under this plan;
- (3) the last day of the month in which the Subscriber requests coverage be cancelled;
- (4) the day before the due date of any premium that remains unpaid at the end of the Grace Period;
- (5) the date the Policy terminates;
- (6) the last day of the month in which an Insured stops meeting the definition of Eligible Dependent; or
- (7) the day the Insured moves outside of the service area for Insured's selected network. Insured may request a plan change if Insured moves within an area where an alternate plan is available.

BEST Life will notify Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of this insurance coverage.

## **PART 6 –PREMIUM PROVISIONS**

**Premium Payments:** Renewal premiums are payable to the Company. The payment of any premium shall not continue this Policy in force beyond the next premium due date, except as provided in the Grace Period provision.

**Changes in Premiums:** We may change the amount of the required premium due from the Policyholder by giving the Policyholder at least sixty (60) days advance written notice. During the first 12 months, We will not change the amount of the required premium.

**Grace Period:** This Policy has a thirty-one (31) day Grace Period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following thirty-one (31) days. During the Grace Period, this Policy will remain in force. If the required premium is not paid by the end of this Grace Period, this Policy will lapse as of the end of the Grace Period.

**Termination of Policy:** We may terminate this Policy at any time following the first renewal date by giving the Policyholder written notice at least sixty (60) days in advance. The Policyholder may also terminate this Policy by giving Us written notice at least sixty (60) days before the intended termination date. This Policy will also terminate if the required premium is not paid by the Policyholder as provided in the Grace Period provision.

**Reinstatement:** If any renewal premium is not paid by the end of the Grace Period, coverage under this Policy will be terminated. However, BEST Life will reinstate this Policy, without requiring an application for reinstatement, as long as premium is paid for at least the sixty (60) days prior to the date of reinstatement. The reinstated Policy will cover only loss resulting from an accidental injury sustained after the date of reinstatement and loss due to sickness beginning ten (10) days after reinstatement. In all other respects the insured and BEST Life shall have the same rights as they had under the Policy immediately before the due date of the defaulted premium, subject to conditions and provisions of the Policy.

## **PART 7 – GENERAL PROVISIONS**

**Clerical Error:** Clerical error by the Policyholder shall not invalidate insurance otherwise validly in force nor continue insurance otherwise validly terminated.

**Third Party Responsibility:** If an Insured is injured or becomes ill through the act or omission of

another person, to the extent that the Insured recovers medical expenses for the same Injury or Illness from a third party or its insurer, We will be entitled to a repayment of any remuneration in excess of benefits paid under the Policy due to the same Injury or Illness, and after the Insured is fully compensated for his or her loss. We may file a lien for such repayment. Upon request, the Insured must complete and return the required forms to Us.

The repayment agreement will be binding upon the Insured, or the legal representative of a minor or incompetent, whether:

- (1) the payment received from the third party, or its insurer, is the result of:
  - legal judgment;
  - an arbitration award;
  - a compromise settlement;
  - any other arrangements; or
- (2) the third party or its insurer had admitted liability for the payment; or
- (3) the medical expenses are itemized in the third party payment.

**Entire Contract; Changes:** The Policy, including the endorsements, certificates, riders, application and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions. We will consider any statement made by the Insured or the Policyholder, in the absence of fraud, as a representation and not a warranty.

**Underwriting Decisions:** If, for any reason, We cannot accept Your application for coverage, We will communicate Our decision to You in writing with the reasons supporting Our decision.

**Notification to Insureds:** BEST Life will notify Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of your insurance, a change in your premium, a change in eligibility or a change in your benefits.

**Right to Contest:** After this Policy has been in force for a period of two (2) years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application. No claim for loss incurred or disability (as defined in the Policy) commencing after two (2) years from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Policy.

**Notice of Claim:** We must receive written notice within twenty (20) days after a claim starts or as soon as reasonably possible. The notice shall be sent to BEST Life and Health Insurance Company at [2505 McCabe Way, Irvine, California 92614] or given it to Our agent.

**Claim Forms:** When We receive a notice of claim, We will send forms for filing the claim. If the Subscriber or Insured do not receive these forms within fifteen (15) days, the Subscriber or Insured may send Us a written statement to satisfy this requirement. This statement should include the nature and extent of the claim and be sent to Us within the time stated in the Proof of Loss provision.

**Proof of Loss:** We must receive written proof of loss within ninety (90) days of a claim. If it is not possible for proof to be provided within the ninety (90) days, We will not deny a claim for this reason if We receive the proof as soon as possible. In any event, We must receive proof no later than one year from the



time specified, unless Subscriber is legally incapacitated.

**Time of Payment of Claims:** Indemnities payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this Policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

**Payment of Claims:** All payments will be made to Subscriber or Insured's provider.

**Legal Actions:** A legal action may not be brought against Us before sixty (60) days, or after three (3) years, from the date written proof of loss is required to be given.

**Time Limit on Certain Defenses:** After this Policy has been in force for two (2) years, We will not use any statements made in the application of the Policyholder to void the Policy. After an Insured Person has been covered under this Policy for two (2) years, We will not use any statement made in the Insured Person's enrollment form to defend a claim.

**Misstatement of Age:** If the age of any individual covered under the Policy has been misstated, there shall be an adjustment of premium for the Policy so that there shall be paid to Us the premium for the coverage of such individual at his or her correct age, and the amount of the insurance coverage shall not be affected.

**Worker's Compensation:** The Policy is not in lieu of and does not affect any requirement for coverage by Worker's Compensation Insurance.

**Conformity with State Statutes:** Any provisions of the Policy which are in conflict with the statutes of the state in which the Policy was issued or delivered will be changed to conform to such laws.

**Waiver of Rights:** If We fail to enforce any provision of the Policy, such failure will not affect Our right to do so at a later date, nor will it affect Our right to enforce any other provision of the Policy.

**Inspection of Policy:** The Policy is in the possession of the Policyholder. It may be inspected at any time during business hours at the office of the Policyholder.

**Duty to Cooperate:** As a condition precedent to the payment of benefits hereunder, the Subscriber and Insured are required to cooperate with Us by providing all information reasonably required to accurately process a claim. Any failure to provide necessary information may result in a denial of benefits for the claim.

## **PART 8 – FILING A DENTAL CLAIM**

**HOW TO FILE A CLAIM:** Claim forms may be obtained from [the BEST Life website located at [www.bestlife.com](http://www.bestlife.com), click on "Forms"].

Submit claims to [BEST Life and Health Insurance Company], [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

For questions about a claim payment, contact BEST Life's Customer Service at [1-800-433-0088 or at [cs@bestlife.com](mailto:cs@bestlife.com), Monday through Friday, 7 am to 5 pm Pacific Time].

**CLAIMS DENIAL PROCEDURE:** Any denial of a claim for Benefits will be explained in writing. The explanation will include (a) the specific reason for the denial, (b) reference to the plan provision upon which the denial was based, (c) a description of any additional information that might be required to provide and an explanation of why it is needed, and (d) an explanation of the plan's claim review procedure.

**APPEALING THE DENIAL OF A CLAIM:** You or an authorized representative You appoint to assist or represent You, may appeal any denial of a claim, in whole or in part, for Benefits by filing a written request for a review. The request must include all reasons You believe the initial decision was incorrect and all documentation supporting Your appeal, to BEST Life and Health Insurance Company, Attn: Appeals, [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

A request for a review must be filed within one-hundred and eighty (180) days after the date on which we issue the written notice of denial of a claim. BEST Life and Health Insurance Company will provide an appeal determination not later than sixty (60) days after receipt of a request for review. If there are special circumstances, the decision will be made as soon as possible, but no later than fifteen (15) days after receipt of the request for review. The appeal determination will be in writing and will include specific reasons for the decision. This decision shall also include specific references to the Policy provisions on which the decision was based.

**Underwritten by BEST Life and Health Insurance Company**

**BEST Life and Health Insurance Company**  
[2505 McCabe Way  
Irvine, California 92614]

**DENTAL POLICY – FORM: IFD-PPO-POL-0113TN**  
**REQUIRED OUTLINE OF COVERAGE**

- A. READ YOUR POLICY CAREFULLY!** This Outline of Coverage provides a very brief description of some of the important features of Your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both You and Us. It is, therefore, important that You **READ YOUR POLICY CAREFULLY**.
- B. Dental coverage** is designed to provide You with benefits described in the **BENEFITS** section below. The benefits described may be limited as outlined in the **LIMITATIONS** and **EXCLUSIONS** section.
- C. BENEFITS**

**SCHEDULE OF BENEFITS**

Covered Services received by Insured from a Network Provider are reimbursed at the Network Provider's contracted Fee Schedule. Covered Services received by Insured from an Out-of-Network Provider are reimbursed at the [80<sup>th</sup>][90<sup>th</sup>] percentile of a Usual, Reasonable and Customary schedule. All Covered Services are subject to Cost Sharing as shown on the Schedule of Benefits. Additional charges may not be covered by this Policy.

**[Pediatric Dental Plan Schedule of Benefits  
For Children to Age 19]**

Procedure Categories	PPO[ High][Low] Pediatric Dental Plan	
	In-Network [Network Name]	Out-of-Network
<b>Out-of-Pocket Maximum</b>	\$700 for 1 Child \$1,400 for 2 or more Children	\$700 for 1 Child \$1,400 for 2 or more Children
<b>Annual Deductible</b> – Applies to Preventive[,] [services received Out-of-Network as well as] Basic and Major services received In-Network or Out-of-Network	\$[0][50]	\$[50][100]
<b>Diagnostic &amp; Preventive Services Coinsurance</b> – Exams, cleanings, sealants, fluoride treatment, x-rays	100%	[90][60]%
<b>Basic Services Coinsurance</b> – Fillings	[70][55]%	[60][40]%
<b>Major Services Coinsurance</b> – Crowns & casts, prosthodontics, endodontics, periodontics, oral surgery	[50][35]%	[40][20]%
<b>Orthodontic Services Coinsurance</b> (Medically necessary Orthodontic Services only)	50% [24 Month Wait]	50% [24 Month Wait]

**[Dental Plan Schedule of Benefits  
For Adults and Dependent Children between 19 and 26]**

	<b>[BESTOne Dental] [Advantage][Plus][Basic] Supplemental Plan</b>	
<b>Benefits Description</b>	<b>In-Network [Network]</b>	<b>Out-of-Network</b>
<b>Annual Maximum</b>	\$[500 – 3,500]	
<b>Annual Deductible</b> (Applies to Basic and Major) – 3 Deductible Maximum per Family	[\$0-100]	
<b>Preventive Care Services</b> Routine oral exam, cleanings, X-rays	[100-70]%	[100-70]%
<b>Basic Services</b> Filings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology	[90-50]%	[80-20]%
<b>Major Services</b> Crowns & gold filings, inlays, onlays & pontics, [implants,] fixed bridges, complete & partial dentures	[60-0]%	[50-0]%
<b>[Major Services Waiting Period]</b>	12 Months]	
<b>Endodontic Services</b>	[Basic][Major]	
<b>Periodontic Services</b>	[Basic][Major]	
<b>Oral Surgery Services</b>	[Basic][Major]	
<b>Usual and Customary Reimbursement</b>	Fee Schedule	[80 <sup>th</sup> ][90 <sup>th</sup> ] Percentile

]

**D. LIMITATIONS**

**COVERED SERVICES ON  
PEDIATRIC DENTAL PLAN**

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Policy.

**Class I – Preventive and Diagnostic Procedures Include:**

- (1) Prophylaxis not more often than once every six (6) months;
- (2) Topical application of fluoride (excluding prophylaxis) not more often than twice every twelve (12) months;
- (3) Topical fluoride varnish not more often than twice every twelve (12) months;
- (4) Sealants not more often than once per tooth in a thirty-six (36) month period and limited to unrestored permanent molars for individuals under age nineteen (19);
- (5) Space maintainers, including re-cementation, for individuals under age nineteen (19) (excluding removal of fixed space maintainer);
- (6) Periodic oral evaluation not more often than once every six (6) months;
- (7) Limited oral evaluation (problem focused) not more often than once every six (6) months;
- (8) Comprehensive oral evaluation not more often than once every six (6) months;
- (9) Comprehensive periodontal evaluation not more often than once every six (6) months;
- (10) Intraoral complete X-rays or panoramic film not more often than once in a 60-month period;
- (11) Bitewing X-rays not more often than one set every six (6) months;

- (12) Single film intraoral periapical or occlusal;
- (13) Palliative treatment of dental pain (minor procedure);

**Class II – Basic Procedures Include:**

- (1) Amalgams, resin-based composites, re-cement inlays, re-cement crowns, protective restoration, pin retention;
- (2) Prefabricated stainless steel crowns not more often than once per tooth in a sixty (60) month period for individuals under age fifteen (15);
- (3) Therapeutic pulpotomy (excluding restoration) if a root canal is not performed within forty-five (45) days of the pulpotomy;
- (4) Partial pulpotomy for apexogenesis limited to permanent tooth with incomplete root development, if a root canal is not performed within forty-five (45) days of pulpotomy;
- (5) Pulpal therapy (excluding final restoration) once per tooth per lifetime, limited to primary incisor teeth for individuals up to age six (6), and limited to primary molars and cuspids for individuals up to age eleven (11);
- (6) Periodontal scaling and root planning, per quadrant, not more often than once every twenty-four (24) months;
- (7) Periodontal maintenance not more often than four in a twelve (12)-month period, combined with adult prophylaxis after the completion of active periodontal therapy;
- (8) Adjustment and repair of complete or partial dentures;
- (9) Rebase and reline not more often than once in a thirty-six (36) month period, six (6) months after initial installation;
- (10) Tissue conditioning;
- (11) Recement fixed partial denture
- (12) Fixed partial denture repair, by report;
- (13) Oral surgery:
  - a. extraction for erupted tooth or exposed root;
  - b. surgical removal of erupted tooth;
  - c. removal of impacted tooth;
  - d. removal of residual tooth roots;
  - e. coronectomy;
  - f. tooth reimplantation;
  - g. surgical access of unerupted tooth;
  - h. alveoloplasty;
  - i. removal of exostosis;
  - j. incision and drainage of abscess;
  - k. suture of recent small wounds up to five (5) cm
  - l. excision of pericoronal gingival;

**Class III – Major Procedures Include:**

- (1) Detailed and extensive oral evaluation;
- (2) Inlays, onlays, crowns, core buildup, including any pins, prefabricated post and core in addition to crown, limited to one per tooth every sixty (60) months;
- (3) Endodontics (root canal)
- (4) Gingivectomy or gingivoplasty, four (4) or more teeth not more often than once every thirty-six (36) months;
- (5) Gingival flap procedure, four (4) or more teeth not more often than once every thirty-six (36) months;
- (6) Osseous surgery, four (4) or more contiguous teeth or bounded teeth spaces per quadrant, not more often than once every thirty-six (36) months;

- (7) Full mouth debridement limited to one (1) per lifetime;
- (8) Complete and partial dentures, including abutments, pontics, onlays, retainers and crowns, not more often than once every sixty (60) months (excludes interim dentures);
- (9) Implants and implant services once every sixty (60) months only if medically necessary;
- (10) Occlusal guard not more often than once in twelve (12) months for individuals thirteen (13) and older with predetermination only;
- (11) General anesthesia or IV sedation;
- (12) Consultation by dentist or physician other than the dentist providing treatment;
- (13) Therapeutic drug injection with predetermination;
- (14) Treatment of post-surgical complications with predetermination.

[**Note:** Unless the twenty-four (24) month waiting period requirement for Medically Necessary Orthodontic services has been met, the services below are not covered benefits for any treatment that began during the twenty-four (24) month period immediately following Your effective date of coverage.]

**Class IV – Medically Necessary Orthodontic Procedures Include:**

- (1) For orthodontia services associated with the repair of cleft palate and palate or other severe craniofacial defects or injury for which the function of speech, swallowing or chewing is restored;
- (2) Requires predetermination; and
- (3) Coverage includes diagnosis, treatment plan, anticipated treatment time and cost estimate.

**[COVERED SERVICES ON  
SUPPLEMENTAL DENTAL PLAN**

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Policy.

**CLASS I - Preventive Dental Procedures include:**

- (1) Routine oral examination and diagnosis not more often than twice every twelve (12) months per individual;
- (2) Bitewing x-rays not more often than once every twelve (12) months per individual;
- (3) Full mouth x-rays or panoramic films are limited to once every five (5) years; any combination of eight (8) or more x-rays (including but not limited to bitewings or periapicals/intraorals) will be combined into a full mouth x-ray series;
- (4) Prophylaxis not more often than once every six (6) months per individual.

**CLASS II - Basic Dental Procedures include:**

- (1) Pathology;
- (2) All fillings other than lab fabricated restorations (composite fillings limited to permanent anterior and posterior teeth);
- (3) Emergency palliative treatment;
- (4) Limited oral exam not more than once every six months;
- (5) Simple extraction, excluding orthodontic extractions unless a orthodontic benefits are a Covered Dental Expense on this Plan;
- (6) Surgical extraction, including impaction:
  - (a) erupted tooth;
  - (b) soft tissue impaction;
  - (c) partial bony impaction;
  - (d) complete bony impaction;

- (7) General anesthesia or intravenous sedation when required for complex oral surgical procedures (partial and complete bony impacted extractions only);
- (8) Periodontics (tissues and gums);
- (9) Periodontal exam (not in addition to a routine oral exam);
- (10) Periodontal maintenance (limited to once every six (6) months per individual following active periodontal treatment) and not on the same visit as a routine prophylaxis;
- (11) Periodontal scaling and root planing (limited to once every 36 months and to two (2) quadrants per visit, and not in addition to a routine prophylaxis);
- (12) Endodontics (pulp capping and root canal); and
- (13) Oral surgery:
  - (a) root recovery (surgical removal of residual root);
  - (b) oral antral fistula closure;
  - (c) removal of a dentigerous or odontogenic cyst;
  - (d) incision and drainage of an abscess;
  - (e) removal of lateral exostosis;
  - (f) frenulectomy.

[**Note:** Unless the twelve (12) month waiting period requirement for Major Dentistry services has been met, the services below are not covered benefits for any treatment that began during the twelve (12) month period immediately following Your effective date of coverage.]

**CLASS III - Major Dental Procedures include:**

- (1) Inlays, onlays, crowns and other lab fabricated restorations (not including veneers);
- (2) Porcelain, porcelain fused to metal, or full gold crowns on permanent teeth;
- (3) Full or partial dentures or fixed bridgework or adding teeth to an existing denture, if required because of loss of functional natural teeth while the person is covered for this Benefit. The work must be done within twelve (12) months after the extraction and while this coverage is in force;
- (4) Replacement or alteration of full or partial dentures or fixed bridgework caused by the following while coverage is in force:
  - (a) accidental injury requiring oral surgical treatment, or
  - (b) oral surgical treatment involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus or redundant tissue, provided the replacement or alteration is done within twelve (12) months of the injury or surgical treatment.
- (5) Replacement of a full denture or bridgework if the replacement is made more than seven (7) years after the date of installation, unless:
  - (a) such replacement is made necessary by the initial extraction of an adjoining functional natural tooth; or
  - (b) the prosthesis, while in the oral cavity, has been damaged beyond repair as a result of a non-chewing injury while covered;
- (6) Repair or reline of dentures and bridgework[;]
- (7) Implants, as an alternative to a fixed prosthetic, (limited to once in a lifetime per site). The cost of the fixed prosthetic will be applied to the total value of the implant and implant-related procedures, not to exceed the cost of the fixed prosthetic:
  - (a) the surgical placement of endosteal implant body including healing cap, where the bone and soft tissues are sound and healthy;
  - (b) implant supported prosthetics;
  - (c) eposteal and transosteal implants will be covered at the cost of the endosteal implant (if performed, member is responsible for additional fees);
  - (d) bone grafting and tooth extractions, provided the work is done while this coverage is in force;
  - (e) implant maintenance[.].



## E. EXCLUSIONS

### EXCLUSIONS ON PEDIATRIC DENTAL PLAN

The following exclusions are not Covered Services. No payments will be made by Us for these services:

- (1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;
- (2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
- (3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
- (4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;
- (5) Services and supplies started and not completed before the patient was covered under this Plan, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
- (6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
- (7) Space maintainers;
- (8) Sealants if re-sealed within a five (5) year period;
- (9) Retreatment of a previous root canal or apicoectomy/periradicular surgery;
- (10) Elective tooth extractions;
- (11) Separate payments for open and drain palliative procedure when the root canal is completed on the same date of service;
- (12) Expenses incurred for gingivectomy or gingivoplasty, periodontal scaling and root planning, full mouth debridement, and periodontal maintenance;
- (13) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are defined as a Covered Dental Expense;
- (14) Charges in excess of Usual, Reasonable and Customary charges amount stated in the "Schedule of Benefits" section of this Plan, or in excess of the Preferred Provider Fee Schedule;
- (15) Charges for service provided for temporomandibular joint dysfunction (TMJ);
- (16) Expenses incurred for congenital or developmental malformations, except as defined as a Covered Orthodontic Expense;
- (17) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits, except as defined as a Covered Orthodontic Expense;
- (18) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
- (19) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, the patient's lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;
- (20) Expenses for services for which the patient would not legally have to pay if there were no insurance, unless mandated by the State;
- (21) Services not completed on or before the date of termination;
- (22) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life

shall be liable only for the amount it would have been liable for had one dentist rendered the services;

- (23) Expenses that are applied toward satisfaction of a Deductible, if any;
- (24) Any service or procedure not commonly found within the scope of practice by a licensed dentist;
- (25) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
- (26) Chemotherapeutic agents and any other experimental procedures;
- (27) Expenses incurred for veneers and related procedures;
- (28) Services and supplies performed outside of the United States of America.

#### **EXCLUSIONS ON SUPPLEMENTAL DENTAL PLAN**

The following exclusions are not Covered Services. No payments will be made by Us for these services:

- (1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;
- (2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
- (3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
- (4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;
- (5) Services and supplies begun and not completed prior to the patient's effective date, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
- (6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
- (7) Pulp capping, if in conjunction with the installation of inlays, onlays or crowns and fillings or other lab fabricated restorations; including but not limited to inlays, onlays and crowns, preventative tests and examinations diagnostic casts and oral cancer screenings, and expenses incurred for sedative fillings, including charges for prescribed drugs, pre-medication or analgesia;
- (8) The initial installation of a prosthetic device (a fixed bridge, implant, or denture), including crowns and inlays which form abutments, to replace teeth missing before You were covered under the Policy, except when it also replaces a tooth that is extracted while covered unless such installation commences after You have remained continuously covered under this plan for at least three years immediately prior to the date such installation commences;
- (9) Implants, implant services and implant supported prosthetics[ are not covered for patients under the age of sixteen (16)];
- (10) Expenses incurred for veneers and related procedures;
- (11) Replacement of a lost or stolen or discarded prosthetic device;
- (12) Adjustment, repairs or relines of prostheses for a period of one (1) year from initial placement if the prostheses were paid for under this plan;
- (13) Expenses incurred for a core buildup will only be considered in conjunction with a crown;
- (14) If multiple endodontic treatments are necessary on the same tooth within a period of one (1) year, the allowance will be made for only one (1) procedure;
- (15) X-rays are considered an integral part of the endodontic procedure rather than a separate

- service and are therefore not eligible for benefits;
- (16) The extraction of immature erupting third molars and non-pathologic, asymptomatic third molar extractions;
  - (17) Expenses for gross debridement allowed one time at the beginning of the periodontal treatment plan prior to pocket depth charting;
  - (18) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
  - (19) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are a Covered Dental Expense on this Plan;
  - (20) Surgical procedures incidental to orthodontic treatment, including but not limited to, extraction of teeth solely for orthodontic reasons, exposure of impacted teeth, correction of micrognathia or macrognathia, or repair of cleft palate;
  - (21) Charges for service provided for temporomandibular joint dysfunction (TMJ);
  - (22) Expenses incurred for congenital or developmental malformations;
  - (23) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
  - (24) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits;
  - (25) Chemotherapeutic agents and any other experimental procedures;
  - (26) Charges in excess of Usual, Reasonable and Customary charges or in excess of the Calendar Year Maximum amount stated in the "Schedule of Dental Benefits" section of this Plan, or in excess of the Preferred Provider Fee Schedule;
  - (27) Expenses that are applied toward satisfaction of a Deductible, if any;
  - (28) Services and supplies performed outside of the United States of America;
  - (29) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, Your lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;
  - (30) Expenses for services for which You would not legally have to pay if there were no insurance;
  - (31) Services not completed on or before the date of termination;
  - (32) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
  - (33) Any service or procedure not commonly found within the scope of practice by a licensed dentist. Such procedures are identified within the current Common Dental Terminology (CDT Codes) published by the American Dental Association;
  - (34) Expenses incurred for services covered on a pediatric only dental plan.]

## **F. RENEWABILITY**

This Policy may be renewed for additional periods of coverage by paying the premium when due or within the Grace Period until You reach age [19][65]. Each period of coverage runs from premium due date to premium due date.

## **G. PREMIUMS**

We may change the amount of the required premium by giving You at least 60 days advance written notice. The Policy has a thirty-one (31) day Grace Period. That means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the Grace Period, the Policy will remain in force. If the required premium is not paid by the end of this Grace Period, the Policy will lapse as of the end of the Grace Period.

[Total Initial Premium due with Application: [XX.XX]]

**Underwritten by BEST Life and Health Insurance Company**

## **Actuarial Memorandum**

### **Scope and Purpose**

This is a new product rate filing to satisfy the Stand-Alone Adult and Pediatric Dental Plans Rate Filing requirements for the Tennessee Health Benefit Plan under individual policy numbers GPD-IM-PPO-POL-0113TN and GAD-IM-PPO-POL-0113TN.

### **Description of Benefits**

The policies provide benefits for two dental products: a Pediatric Dental Only Plan and an Adult Dental Plan. These plans are provided through the BEST Employers Association, a California corporation, and are designed to be marketed to individuals through the Tennessee Exchange market.

Children to age 20 are eligible to enroll on the Pediatric Dental Only Plan. Adults and child dependents age 21 through age 25 are eligible to enroll on the Adult Dental Plan.

### **Benefit Renewability**

The policies are standard individual contracts. Coverage for individuals is renewable at the option of the policyholder. The Company reserves the right to increase premiums.

### **Proposed Effective Date**

January 1, 2014

### **Description of Rate Calculations**

- Base claim costs are developed using our company California claims experience from 2010 to 2012.
- Base claim costs are adjusted to reflect the plan design and adjusted for area using the 2010 HealthMaps Dental Rate Manual and Milliman study dated November 2012.
- A dental trend factor of approximately 4% per year is used to project future expected claims and is included in the premium rate structure
- Standard company retention of 30.75% (administration – 12%, premium tax – 1.75%, user fees – 3.5%, commissions – 10% and profit – 3.5%) is applied.

### Anticipated Future Loss Ratio

The anticipated future loss ratio for this policy is expected to be 69.25%. The loss ratio is computed as follows:

$$\text{Loss Ratio} = \frac{\text{Expected Incurred Claims}}{\text{Expected Earned Premium}}$$

Incurred claims are total claims for covered expenses paid on behalf of a covered person while coverage is in force, summed for all covered persons. Earned premium is the premium for each covered person for the period coverage is in force, summed for all covered persons.

I, Adam S. Chan, Actuary for BEST Life and Health Insurance Company ("BEST"), NAIC #90638, domiciled in Texas, do hereby certify that to the best of my knowledge and judgment, this rate submission is in compliance with the applicable laws and regulations of Tennessee and all applicable Actuarial Standards of Practice, including ASOP No. 8, and that the attached rates are reasonable in relation to the benefits provided and are not excessive, inadequate, or unfairly discriminatory.



Adam Chan, A.S.A., M.A.A.A.  
Corporate Actuary  
BEST Life and Health Insurance Company  
Irvine, California

April 30, 2013  
Date

## Tennessee Health Insurance Exchange Rate Filing

### Individual Dental - Essential Pediatric Plans

High Plan - Actuarial Value 84%		Low Plan - Actuarial Value 69%	
1 child	2 or more child	1 child	2 or more child

Base Cost	\$ 67.47	\$ 132.47	\$ 59.52	\$ 116.87
Trend	1.12	1.12	1.12	1.12
Area factor	0.80	0.80	0.80	0.80
Net Cost	\$ 60.65	\$ 119.07	\$ 53.50	\$ 105.05

Administrative	12.00%	12.00%	12.00%	12.00%
Premium Tax	1.75%	1.75%	1.75%	1.75%
User Fees*	3.50%	3.50%	3.50%	3.50%
Broker Commission	10.00%	10.00%	10.00%	10.00%
Profit	3.50%	3.50%	3.50%	3.50%

Target Loss Ratio	69.25%	69.25%	69.25%	69.25%
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Final Rate*	\$ 87.58	\$ 171.95	\$ 77.26	\$ 151.70
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*\* User fees of 3.5% imposed by the Department of Health and Human Services are included.*

**Tennessee Health Insurance Exchange Rate Filing**

**Individual Dental - Supplemental Plans**

	High Plan	Mid Plan	Basic Plan	Value Plan
Base Cost	\$ 88.48	\$ 78.92	\$ 55.24	\$ 36.09
Trend	1.12	1.12	1.12	1.12
Area factor	0.80	0.80	0.80	0.80
Net Cost	\$ 79.54	\$ 70.94	\$ 49.66	\$ 32.44
Administrative	12.00%	12.00%	12.00%	12.00%
Premium Tax	1.75%	1.75%	1.75%	1.75%
User Fees*	3.50%	3.50%	3.50%	3.50%
Broker Commission	10.00%	10.00%	10.00%	10.00%
Profit	3.50%	3.50%	3.50%	3.50%
Target Loss Ratio	69.25%	69.25%	69.25%	69.25%
Final Voluntary Tier Rates*				
Employee	\$ 126.80	\$ 113.10	\$ 79.16	\$ 51.71
Employee + Spouse	\$ 258.65	\$ 230.70	\$ 161.48	\$ 105.49
Employee + Children	\$ 272.43	\$ 243.00	\$ 170.09	\$ 111.11
Employee + Family	\$ 441.61	\$ 393.90	\$ 275.71	\$ 180.10
Final Employer-Contributory Tier Rates*				
Employee	\$ 111.58	\$ 99.53	\$ 69.66	\$ 45.51
Employee + Spouse	\$ 227.61	\$ 203.02	\$ 142.10	\$ 92.83
Employee + Children	\$ 239.74	\$ 213.84	\$ 149.68	\$ 97.77
Employee + Family	\$ 388.62	\$ 346.63	\$ 242.62	\$ 158.49

\* User fees of 3.5% imposed by the Department of Health and Human Services are included.



**Individually Underwritten  
Association Insurance Policy**

**Dental PPO Pediatric Plan**



[2505 McCabe Way  
Irvine, California 92614]

**Notice to Buyer: This Policy provides dental coverage for children only.**

**BEST Life and Health Insurance Company**  
[2505 McCabe Way  
Irvine, California 92614]

A STOCK COMPANY  
(Herein called the Company)

**BEST Life and Health Insurance Company**, in consideration of the application of the Subscribing Employer and the payment of premiums as due, agrees, subject to the terms and conditions of this Group Policy, to insure Eligible Employees of Subscribing Employers to the Group Policyholder and their eligible Dependents under this Group Policy.

**GOVERNING JURISDICTION:** The Group Policy is issued in the State of California. Its terms are governed by and shall be construed in accordance with the laws of the Governing Jurisdiction.

This Group Policy becomes effective at 12:01 a.m., Standard Time at the office of the Group Policyholder on the Group Policy Effective Date in the State of Delivery specified below. Subject to the terms and conditions of this Group Policy, it can be renewed until the First Renewal Date by timely payment of the required premium by the Group Policyholder. Unless terminated in accordance with the applicable provision of this Group Policy, it can be renewed after such time from month to month, subject to the terms and conditions of this Group Policy, by timely payment of the required premium.

**NOTICE OF TEN DAY RIGHT TO EXAMINE:** We want You to fully understand and be satisfied with the insurance coverage. If for any reason You are not satisfied, You may return this Group Policy to the agent or to Our home office within ten days of receipt and the premium will be fully refunded. Coverage will then be void retroactive to the Insurance Effective Date.

This Group Policy may be modified by mutual agreement between the Group Policyholder and Us.

The provisions and the terms in the Certificate are part of this Group Policy. A copy of the Certificate is attached to, and made a part of this Group Policy.

Signed for **BEST Life and Health Insurance Company** by its President and Secretary at [2505 McCabe Way, Irvine, California 92614.]

[ 

**President**

II



**Secretary**

**Group PPO  
Pediatric Dental Policy  
Non-Participating**

**Group Policyholder:** BEST Employers Association

**Group Policy Effective Date:** [XX-XX-XXXX]

**Group Policy Number:** [XXX]

**State of Delivery:** California

**Premiums Due On:** 1<sup>st</sup> of each month

**First Renewal Date:** [XX-XX-XXXX]

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## PART 1 - SCHEDULE OF BENEFITS

This Certificate of Group Coverage is made valid on the effective dates shown for the listed Insureds on the Statement of Coverage.

The Policy is issued by **BEST Life and Health Insurance Company** to: [BEST Employers Association].

Covered Services received by Insured from a Network Provider are reimbursed at the Network Provider's contracted Fee Schedule. Covered Services received by Insured from an Out-of-Network Provider are reimbursed at the 80th percentile of a Usual, Reasonable and Customary schedule. All Covered Services are subject to Cost Sharing as shown on this Schedule of Benefits.

Procedure Categories	PPO High Pediatric Dental Plan	
	In-Network [Network Name]	Out-of-Network
<b>Out-of-Pocket Maximum</b>	\$700 for 1 Child \$1,400 for 2 or more Children	\$700 for 1 Child \$1,400 for 2 or more Children
<b>Annual Deductible</b> – Applies to Basic and Major services received In-Network or Out-of-Network	\$0	\$50
<b>Diagnostic &amp; Preventive Services Coinsurance</b> – Exams, cleanings, sealants, fluoride treatment, x-rays	100%	90%
<b>Basic Services Coinsurance</b> – Fillings	70%	60%
<b>Major Services Coinsurance</b> – Crowns & casts, prosthodontics, endodontics, periodontics, oral surgery	50%	40%
<b>Orthodontic Services Coinsurance</b> (Medically necessary Orthodontic Services only)	50%	50%

]

PPO Low Pediatric Dental Plan		
Procedure Categories	In-Network [Network Name]	Out-of-Network
<b>Out-of-Pocket Maximum</b>	\$700 for 1 Child \$1,400 for 2 or more Children	\$700 for 1 Child \$1,400 for 2 or more Children
<b>Annual Deductible</b> – Applies to Preventive, Basic and Major services received In-Network or Out-of-Network	\$50	\$100
<b>Diagnostic &amp; Preventive Services Coinsurance</b> – Exams, cleanings, sealants, fluoride treatment, x-rays	100%	60%
<b>Basic Services Coinsurance</b> – Fillings	55%	40%
<b>Major Services Coinsurance</b> – Crowns & casts, prosthodontics, endodontics, periodontics, oral surgery	35%	20%
<b>Orthodontic Services Coinsurance</b> (Medically necessary Orthodontic Services only)	50%	50%

## PART 2 - BENEFITS

### Covered Services

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Certificate.

#### Class I – Preventive and Diagnostic Procedures Include:

- (1) Prophylaxis not more often than once every 6 months;
- (2) Topical application of fluoride (excluding prophylaxis) not more often than twice every 12 months;
- (3) Topical fluoride varnish not more often than twice every 12 months;
- (4) Sealants not more often than once per tooth in a 36-month period and limited to unrestored permanent molars for individuals under age 19;
- (5) Space maintainers, including re-cementation, for individuals under age 19 (excluding removal of fixed space maintainer);
- (6) Periodic oral evaluation not more often than once every 6 months;
- (7) Limited oral evaluation (problem focused) not more often than once every 6 months;
- (8) Comprehensive oral evaluation not more often than once every 6 months;
- (9) Comprehensive periodontal evaluation not more often than once every 6 months;
- (10) Intraoral complete X-rays or panoramic film not more often than once in a 60-month period;
- (11) Bitewing X-rays not more often than one set every 6 months;

- (12) Single film intraoral periapical or occlusal;
- (13) Palliative treatment of dental pain (minor procedure);

**Class II – Basic Procedures Include:**

- (1) Amalgams, resin-based composites, re-cement inlays, re-cement crowns, protective restoration, pin retention;
- (2) Prefabricated stainless steel crowns not more often than once per tooth in a 60-month period for individuals under age 15;
- (3) Therapeutic pulpotomy (excluding restoration) if a root canal is not performed within 45 days of the pulpotomy;
- (4) Partial pulpotomy for apexogenesis limited to permanent tooth with incomplete root development, if a root canal is not performed within 45 days of pulpotomy;
- (5) Pulpal therapy (excluding final restoration) once per tooth per lifetime, limited to primary incisor teeth for individuals up to age 6, and limited to primary molars and cuspids for individuals up to age 11;
- (6) Periodontal scaling and root planning, per quadrant, not more often than once every 24 months;
- (7) Periodontal maintenance not more often than four in a 12-month period, combined with adult prophylaxis after the completion of active periodontal therapy;
- (8) Adjustment and repair of complete or partial dentures;
- (9) Rebase and reline not more often than once in a 36-month period, 6 months after initial installation;
- (10) Tissue conditioning;
- (11) Recement fixed partial denture
- (12) Fixed partial denture repair, by report;
- (13) Oral surgery:
  - a. extraction for erupted tooth or exposed root;
  - b. surgical removal of erupted tooth;
  - c. removal of impacted tooth;
  - d. removal of residual tooth roots;
  - e. coronectomy;
  - f. tooth reimplantation;
  - g. surgical access of unerupted tooth;
  - h. alveoloplasty;
  - i. removal of exostosis;
  - j. incision and drainage of abscess;
  - k. suture of recent small wounds up to 5 cm
  - l. excision of pericoronal gingival;

**Class III – Major Procedures Include:**

- (1) Detailed and extensive oral evaluation;
- (2) Inlays, onlays, crowns, core buildup, including any pins, prefabricated post and core in addition to crown, limited to one per tooth every 60 months;
- (3) Endodontics (root canal)
- (4) Gingivectomy or gingivoplasty, four or more teeth not more often than once every 36 months;
- (5) Gingival flap procedure, four or more teeth not more often than once every 36 months;
- (6) Osseous surgery, four or more contiguous teeth or bounded teeth spaces per quadrant, not more often than once every 36 months;
- (7) Full mouth debridement limited to one per lifetime;
- (8) Complete and partial dentures, including abutments, pontics, onlays, retainers and crowns, not more often than once every 60 months (excludes interim dentures);



- (9) Implants and implant services once every 60 months only if medically necessary;
- (10) Occlusal guard not more often than once in 12 months for individuals 13 and older with predetermination only;
- (11) General anesthesia or IV sedation;
- (12) Consultation by dentist or physician other than the dentist providing treatment;
- (13) Therapeutic drug injection with predetermination;
- (14) Treatment of post-surgical complications with predetermination.

**Class IV – Orthodontic Procedures Include:**

- (1) For orthodontia services associated with the repair of cleft palate and palate or other severe craniofacial defects or injury for which the function of speech, swallowing or chewing is restored;
- (2) Requires predetermination; and
- (3) Coverage includes diagnosis, treatment plan, anticipated treatment time and cost estimate.

**PART 3 - LIMITATIONS AND COST SHARING**

**ACCESS TO CARE**

**Using a Network Provider:**

BEST Life offers Insureds the option to save on out-of-pocket costs when care is provided by a Network Provider. A listing of General Dentists and Specialists is available. To find a Network Provider, please refer to the Network information provided on the ID Card.

**How to Select a Dentist:**

Insureds on this Plan may obtain dental services from any licensed dental professional in the United States. To use the Plan, Insureds may directly contact the dentist of their choice and make an appointment. Insureds are advised to bring their ID Card to their appointment. The dentist may require a copy of the Insured's ID Card to confirm eligibility on this Plan.

**How to Obtain a Referral:**

A dentist may determine that an Insured requires treatment from a dental provider that specializes in a type of dentistry (Specialist). The Insured does not need to contact BEST Life for a referral. The Insured can directly contact the Specialist to make an appointment. The Specialist may require information from the Insured's dentist to determine a treatment plan and may contact the dentist directly.

**ADVANCE NOTICE OF DENTAL TREATMENT**

Subscriber or Insured should submit Advance Notice of Dental Treatment before treatment commences in order to obtain Predetermination of Covered Services, including services that are medically necessary. If dental services are performed without such Predetermination, We reserve the right to deny any claim submitted with respect to such Covered Services; provided however, that predetermination is not required for:

- (1) Covered Services for which the related expense is less than \$500 during any course of treatment ("course of treatment" means one treatment or one of a planned series of treatments resulting from dental examination);
- (2) Emergency treatment; or
- (3) Oral examination and prophylaxis.

Predetermination is required for the following dental services:

- (1) Medically necessary service or supplies;

- (2) Crowns (other than stainless steel);
- (3) Apicoectomy;
- (4) Non-emergency third molar extractions;
- (5) Maxillofacial prosthetics;
- (6) Orthodontia;
- (7) Emergency room services provided by a dentist; and
- (8) Inpatient hospital services.

We will have 30 days to furnish the provider with an Explanation of Benefits demonstrating whether the proposed treatment will be a Covered Service under this Policy.

### **DEDUCTIBLES**

**Annual Deductible:** The Annual Deductible shown in the Schedule of Dental Benefits will apply separately to each Insured. Each Insured must accumulate eligible expenses equal to the deductible amount.

### **ALTERNATIVE PROCEDURES**

If more than one treatment plan exists for a dental procedure, covered dental expenses will be based on the least expensive procedure that will produce a result that meets professionally recognized standards. If the Insured's provider elects the more expensive treatment, the Insured or Subscriber shall be responsible for any charges that are greater than the covered expense for the less expensive treatment.

### **PART 4 – EXCLUSIONS**

The following exclusions are not Covered Services. No payments will be made by Us for these services:

- (1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;
- (2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
- (3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
- (4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;
- (5) Services and supplies started and not completed before the patient was covered under this Plan, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
- (6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
- (7) Space maintainers;
- (8) Sealants if re-sealed within a 5-year period;
- (9) Retreatment of a previous root canal or apicoectomy/periradicular surgery;
- (10) Elective tooth extractions;
- (11) Separate payments for open and drain palliative procedure when the root canal is completed on the same date of service;

- (12) Expenses incurred for gingivectomy or gingivoplasty, periodontal scaling and root planning, full mouth debridement, and periodontal maintenance;
- (13) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are defined as a Covered Dental Expense;
- (14) Charges in excess of Usual, Reasonable and Customary charges amount stated in the "Schedule of Benefits" section of this Plan, or in excess of the Preferred Provider Fee Schedule;
- (15) Charges for service provided for temporomandibular joint dysfunction (TMJ);
- (16) Expenses incurred for congenital or developmental malformations, except as defined as a Covered Orthodontic Expense;
- (17) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits, except as defined as a Covered Orthodontic Expense;
- (18) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
- (19) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, the patient's lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;
- (20) Expenses for services for which the patient would not legally have to pay if there were no insurance, unless mandated by the State;
- (21) Services not completed on or before the date of termination;
- (22) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
- (23) Expenses that are applied toward satisfaction of a Deductible, if any;
- (24) Any service or procedure not commonly found within the scope of practice by a licensed dentist;
- (25) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
- (26) Chemotherapeutic agents and any other experimental procedures;
- (27) Expenses incurred for veneers and related procedures;
- (28) Services and supplies performed outside of the United States of America.

## **PART 5 - DEFINITIONS**

**Annual:** The twelve (12) month period beginning on the effective date of the Certificate and ending on the termination date of the Certificate. The Annual time frame will be applied to the Deductible and the Out-of-Pocket Maximum amount.

**Annual Deductible:** The amount each Insured must satisfy before Benefits are payable by Us. To satisfy the Annual Deductible, the Insured must accumulate expenses for Covered Services equal to the Deductible amount shown on the Schedule of Benefits.

**Certificate Effective Date:** The date shown on the Statement of Coverage as the Certificate Effective Date.

**Child:** A person who is less than 20 years of age on the effective date of the person's coverage.

**Coinsurance:** The amount of an expense for a Covered Service that we will pay once the deductible is satisfied.

**Covered Service:** A service or supply listed as a Covered Service and not otherwise limited or excluded by this Certificate. A Covered Service must be provided by a doctor of medical dentistry or a doctor of dental surgery, or a dentist.

**Eligible Dependent:** A Child, including a natural child, step-child, foster child, lawfully adopted child or child in the process of being adopted from the date of placement, any child for whom the Subscriber has been granted legal custody, or a Child named in a Qualified Medical Child Support Order or other court or administrative order.

**Emergency Care:** A dental emergency where an acute disorder of oral health requires dental and/or medical attention, including broken, loose, or evulsed teeth caused by traumas; infections and inflammations of the soft tissues of the mouth; and complications of oral surgery, such as dry tooth socket.

**Grace Period:** A Grace Period of thirty-one (31) days from the due date will be allowed for payment of each premium after the first. This coverage will remain in effect during the Grace Period; provided the premium is paid before the end of the Grace Period.

**Insured:** Any Eligible Dependent of a Subscriber who is enrolled in and covered under the Policy.

**Medically Necessary:** The determination process that may include, and not limited to, the evaluation of the effectiveness and benefit of a dental service or supply for the individual patient based on scientific evidence considerations, up-to-date and consistent professional standards of care, convincing expert opinion and a comparison to alternative interventions, including interventions, and the cost effectiveness of such service or supply. Medical necessity may be obtained by applying an Advance Notice of Treatment.

**Network Provider:** A dental care professional that is contracted with Us and is part of the Network shown on the Schedule of Benefits.

**Out-of-Network Provider:** A dental care professional that is not a Network Provider.

**Out-of-Pocket Maximum:** The total amount of expenses related to Covered Services, in addition to the Deductible, that must be paid on behalf of an Insured on an Annual basis.

**Plan:** Means any Plan providing benefits or services for or by reason of dental care or treatment, which benefits or services are provided in: (1) group, blanket or franchise insurance coverage; (2) group practice and other group prepayment coverage; (3) group service Plans; (4) any coverage under labor management trustee Plans, union welfare Plans, Employer organization Plans or Employee benefit organization Plans; and (5) any coverage under governmental programs, and any coverage required or provided by any statute. For purposes of coordinating benefits under this Policy, the term "Plan" shall not include any plan of individual coverage or school or church accident type coverages.

The term "Plan" shall be construed separately with respect to each Policy, contract or other arrangement for benefits or services and separately with respect to that portion of such Policy, contract or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

**Statement of Coverage:** The proof of insurance issued to an individual insured under the Policy, outlining the insurance benefits and principle provisions applicable to the member.

**Subscriber:** The person paying premiums to provide coverage on behalf of the Insured; may be the Insured.

**Usual, Reasonable and Customary:** The charge for health care that is consistent with the average rate or charge for identical or similar services in a certain geographical area.

**You or Your:** Means the Insured.

## **PART 6 - COVERAGE EFFECTIVE AND TERMINATION DATES**

### **EFFECTIVE DATE**

**Coverage:** The Insured's coverage will take effect on the Insured's Effective Date as shown on the Statement of Coverage.

### **TERMINATION OF INSURANCE**

The Insured's coverage will stop on the earliest of the following dates:

- (1) the last day of the month in which the Subscriber stops being a member of the Association;
- (2) the last day of the month in which the Insured stops being a member of a class eligible for insurance under this plan;
- (3) the last day of the month in which the Subscriber requests coverage be cancelled;
- (4) the day before the due date of any premium that remains unpaid at the end of the Grace Period;
- (5) the date the Policy terminates;
- (6) the last day of the month in which an Insured stops meeting the definition of Eligible Dependent;
- (7) the day the Insured moves outside of the service area for Insured's selected network. Insured may request a plan change if Insured moves within an area where an alternate plan is available.

BEST Life will notify the Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of this insurance coverage.

## **PART 7 - COORDINATION OF BENEFITS**

**Benefits Subject to this Provision:** All of the benefits provided under the Policy are subject to this provision.

If an Insured is covered by two or more group health insurance policies, the policies may coordinate benefits. Group insurance was designed to cover dental expenses; however, it was never intended to pay in excess of 100% of incurred charges. Coordination of Benefits is established as a method by which two or more carriers or plans could coordinate their respective benefits so the total benefit paid does not exceed 100% of the total allowable expenses incurred.

When there are two or more group carriers involved, one of the carriers is primary and one is secondary. This continues for all carriers involved. The primary carrier pays first, the secondary carrier pays second. This continues for all carriers involved. The order of the carriers is determined, as follows:

**Dependent Children of Non-Separated or Divorced Parents:** The plan covering the parent whose birthday falls earlier in the year is the primary carrier for an Insured under this Certificate. If both parents have the same birthday, the plan that has provided coverage longer is the primary carrier.

**Dependent Children of Separated or Divorced Parents:** The plans must pay in the following order:

- First, the plan of the parent with custody of the child;
- Then, the plan of the spouse or domestic partner of the parent with custody of the child;
- Finally, the plan of the parent not having custody of the child.

However, if terms of a court decree state that one parent is responsible for the health care expenses of the child, and the insurance company has been advised of the responsibility, that plan is primary carrier over the plan of the other parent.

**Dependent Children of Parents With Joint Custody:** The birthday rule applies in this situation.

**Right to Receive and Release Necessary Information:** For the purpose of determining the applicability of and implementing the terms of this provision of this Plan or any provisions of similar purpose of any other Plan, We may, with the consent of any person, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which We deem to be necessary for such purposes. Such information may include information for payment of claims, information to administer your benefits or information to determine medical necessity with our case manager. Any person claiming benefits under this Plan shall furnish to Us such information as may be necessary to implement this provision.

**Facility of Payment:** Whenever payments which should have been made under this Plan in accordance with the Policy have been made under any other Plans, We shall have the right to pay over to any organizations making such other payments any amounts to satisfy our obligation under the policy, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, We shall be fully discharged from liability under this Plan.

**Right to Recovery:** Whenever payments have been made by Us with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, We shall have the right to recover such payments, to the extent of such excess, from among one or more of the following: any persons to or for or with respect to whom such payments are made, any other insurers, service Plans or any other organizations.

## **PART 8 –PREMIUM PROVISIONS**

**Premium Payments:** Renewal premiums are payable to the Company. The payment of any premium shall not continue this Policy in force beyond the next premium due date, except as provided in the Grace Period provision.

**Changes in Premiums:** We may change the amount of the required premium due from the Policyholder by giving the Policyholder at least sixty (60) days advance written notice. During the first 12 months, We will not change the amount of the required premium.

**Grace Period:** This Policy has a thirty-one (31) day Grace Period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following thirty-one (31) days. During the Grace Period, this Policy will remain in force. If the required premium is not paid by the end of this Grace Period, this Policy will lapse as of the end of the Grace Period.

**Termination of Policy:** We may terminate this Policy at any time following the first renewal date by giving the Policyholder written notice at least sixty (60) days in advance. The Policyholder may also terminate this Policy by giving Us written notice at least sixty (60) days before the intended termination date. This Policy will also terminate if the required premium is not paid by the Policyholder as provided in the Grace Period provision.

**Reinstatement:** If any renewal premium is not paid by the end of the Grace Period, coverage under this Policy will be terminated. However, BEST Life will reinstate this Policy, without requiring an application for reinstatement, as long as premium is paid for at least the sixty (60) days prior to the date of reinstatement. The reinstated policy will cover only loss resulting from an accidental injury sustained after the date of reinstatement and loss due to sickness beginning ten (10) days after reinstatement. In all other respects the insured and BEST Life shall have the same rights as they had under the policy immediately before the due date of the defaulted premium, subject to conditions and provisions of the Policy.

## **PART 9 – GENERAL PROVISIONS**

**Clerical Error:** Clerical error by the Policyholder shall not invalidate insurance otherwise validly in force nor continue insurance otherwise validly terminated.

**Third Party Responsibility:** If an Insured is injured or becomes ill through the act or omission of another person, to the extent that the Insured recovers medical expenses for the same Injury or Illness from a third party or its insurer, We will be entitled to a repayment of any remuneration in excess of benefits paid under the Policy due to the same Injury or Illness, and after the Insured is fully compensated for his or her loss. We may file a lien for such repayment. Upon request, the Insured must complete and return the required forms to Us.

The repayment agreement will be binding upon the Insured, or the legal representative of a minor or incompetent, whether:

- (1) the payment received from the third party, or its insurer, is the result of:
  - legal judgment;
  - an arbitration award;
  - a compromise settlement;
  - any other arrangements; or
- (2) the third party or its insurer had admitted liability for the payment; or
- (3) the dental expenses are itemized in the third party payment.

**Entire Contract; Changes:** The policy, including the endorsements, certificates, riders, application and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions. We will consider any statement made by the Insured or the Policyholder, in the absence of fraud, as a representation and not a warranty.

**Underwriting Decisions:** If, for any reason, We cannot accept Your application for coverage, We will communicate Our decision to You in writing with the reasons supporting Our decision.

**Notification to Insureds:** BEST Life will notify Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of your insurance, a change in your premium, a change in eligibility or a change in your benefits. This notice will be given to the appropriate insurance producer and the appropriate administrator, if any, along with non-employee

certificate holders.

**Right to Contest:** After this policy has been in force for a period of two (2) years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application. No claim for loss incurred or disability (as defined in the policy) commencing after two (2) years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

**Notice of Claim:** We must receive written notice within twenty (20) days after a claim starts or as soon as reasonably possible. The notice shall be sent to BEST Life and Health Insurance Company at [2505 McCabe Way, Irvine, California 92614] or given it to Our agent.

**Claim Forms:** When We receive a notice of claim, We will send forms for filing the claim. If the Subscriber or Insured do not receive these forms within fifteen (15) days, the Subscriber or Insured may send Us a written statement to satisfy this requirement. This statement should include the nature and extent of the claim and be sent to Us within the time stated in the Proof of Loss provision.

**Proof of Loss:** We must receive written proof of loss within ninety (90) days of a claim. If it is not possible for proof to be provided within the ninety (90) days, We will not deny a claim for this reason if We receive the proof as soon as possible. In any event, We must receive proof no later than one year from the time specified, unless Subscriber is legally incapacitated.

**Time of Payment of Claims:** Indemnities payable under this Policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this Policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

**Payment of Claims:** All payments will be made to Subscriber or Insured's provider.

**Legal Actions:** A legal action may not be brought against Us before sixty (60) days, or after three (3) years, from the date written proof of loss is required to be given.

**Time Limit on Certain Defenses:** After this Policy has been in force for two (2) years, We will not use any statements made in the application of the Policyholder to void the Policy. After an Insured Person has been covered under this Policy for two (2) years, We will not use any statement made in the Insured Person's enrollment form to defend a claim.

**Misstatement of Age:** If the age of any individual covered under the Policy has been misstated, there shall be an adjustment of premium for the Policy so that there shall be paid to Us the premium for the coverage of such individual at his or her correct age, and the amount of the insurance coverage shall not be affected.

**Worker's Compensation:** The Policy is not in lieu of and does not affect any requirement for coverage by Worker's Compensation Insurance.

**Conformity with State Statutes:** Any provisions of the Policy which are in conflict with the statutes of the



state in which the Policy was issued or delivered will be changed to conform to such laws.

**Waiver of Rights:** If We fail to enforce any provision of the Policy, such failure will not affect Our right to do so at a later date, nor will it affect Our right to enforce any other provision of the Policy.

**Inspection of Policy:** The Policy is in the possession of the Policyholder. It may be inspected at any time during business hours at the office of the Policyholder.

**Duty to Cooperate:** As a condition precedent to the payment of benefits hereunder, the Subscriber and Insured are required to cooperate with Us by providing all information reasonably required to accurately process a claim. Any failure to provide necessary information may result in a denial of benefits for the claim.

## **PART 10 – FILING A DENTAL CLAIM**

**HOW TO FILE A CLAIM:** Claim forms may be obtained from [the BEST Life website located at [www.bestlife.com](http://www.bestlife.com), click on “Forms”].

Submit claims to [BEST Life and Health Insurance Company], [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

For questions about a claim payment, contact BEST Life’s Customer Service at [1-800-433-0088 or at [cs@bestlife.com](mailto:cs@bestlife.com), Monday through Friday, 7 am to 5 pm Pacific Time].

**CLAIMS DENIAL PROCEDURE:** Any denial of a claim for Benefits will be explained in writing. The explanation will include (a) the specific reason for the denial, (b) reference to the plan provision upon which the denial was based, (c) a description of any additional information that might be required to provide and an explanation of why it is needed, and (d) an explanation of the plan's claim review procedure.

**APPEALING THE DENIAL OF A CLAIM:** You or an authorized representative You appoint to assist or represent You, may appeal any denial of a claim, in whole or in part, for Benefits by filing a written request for a review. The request must include all reasons You believe the initial decision was incorrect and all documentation supporting Your appeal, to BEST Life and Health Insurance Company, Attn: Appeals, [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

A request for a review must be filed within one-hundred and eighty (180) days after the date on which we issue the written notice of denial of a claim. BEST Life and Health Insurance Company will provide an appeal determination not later than sixty (60) days after receipt of a request for review. If there are special circumstances, the decision will be made as soon as possible, but no later than fifteen (15) days after receipt of the request for review. The appeal determination will be in writing and will include specific reasons for the decision. This decision shall also include specific references to the Policy provisions on which the decision was based.

**Underwritten by BEST Life and Health Insurance Company**

**Individually Underwritten  
Association Insurance Policy**

**Dental PPO Pediatric Plan**



[2505 McCabe Way  
Irvine, California 92614]

**Notice to Buyer: This Certificate provides dental coverage for children only.**

## CERTIFICATE OF GROUP INSURANCE

Issued By

**BEST Life and Health Insurance Company**

A STOCK COMPANY

(Herein called the "We," "Us," "Company" or "BEST Life")

**BEST Life and Health Insurance Company** certifies that Insureds are covered for the benefits described in this Certificate, subject to the limitations and exclusions of this Certificate and of the Policy. The Policy is the contract between BEST Life and the Policyholder named on the Schedule of Benefits. The Policy may be changed or ended without the consent of or notice to the Certificate holder.

This Certificate replaces any certificate previously issued by BEST Life.

**PLAN EFFECTIVE DATE:** Insurance is in effect on the date shown on the Certificate Statement of Coverage.

**GOVERNING JURISDICTION:** The Policy is issued in the State of California. It shall be construed in accordance with the laws of the issuing State.

BEST Life and Health Insurance Company's President and Secretary signed this at [2505 McCabe Way, Irvine, California 92614].



[

]

**President**



[

]

**Secretary**

**GROUP PPO PEDIATRIC  
DENTAL NON-PARTICIPATING**

**THIS INSURANCE DOES NOT COVER INJURIES OR ILLNESSES THAT HAPPEN IN THE  
COURSE AND SCOPE OF EMPLOYMENT. ASK YOUR PARTICIPATING EMPLOYER WHETHER  
YOU ARE PART OF A WORKERS' COMPENSATION SYSTEM.**

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**This Certificate Is Not Valid  
Unless There Is a Complete Statement of Coverage**

**Statement of Coverage**

**PEDIATRIC DENTAL**

**INSURANCE SUBSCRIBER NAME:** [JOHN D. DOE]  
**CERTIFICATE EFFECTIVE DATE:** [01/01/2014]

**INSURED NAME(S) AND EFFECTIVE DATE(S):**

[JANE DOE 01/01/2014]  
[JON DOE 01/01/2014]

**[PLAN:** [PPO HIGH]  
**DEDUCTIBLE:** [\$50]  
**OUT OF POCKET MAXIMUM:** [\$700]]

**GROUP POLICY NO.:** [XXXXXXXXXX]]

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## PART 1 - SCHEDULE OF BENEFITS

This Certificate of Group Coverage is made valid on the effective dates shown for the listed Insureds on the Statement of Coverage.

The Policy is issued by **BEST Life and Health Insurance Company** to: [BEST Employers Association].

Covered Services received by Insured from a Network Provider are reimbursed at the Network Provider's contracted Fee Schedule. Covered Services received by Insured from an Out-of-Network Provider are reimbursed at the 80th percentile of a Usual, Reasonable and Customary schedule. All Covered Services are subject to Cost Sharing as shown on this Schedule of Benefits.

Procedure Categories	PPO High Pediatric Dental Plan	
	In-Network [Network Name]	Out-of-Network
<b>Out-of-Pocket Maximum</b>	\$700 for 1 Child \$1,400 for 2 or more Children	\$700 for 1 Child \$1,400 for 2 or more Children
<b>Annual Deductible</b> – Applies to Basic and Major services received In-Network or Out-of-Network	\$0	\$50
<b>Diagnostic &amp; Preventive Services Coinsurance</b> – Exams, cleanings, sealants, fluoride treatment, x-rays	100%	90%
<b>Basic Services Coinsurance</b> – Fillings	70%	60%
<b>Major Services Coinsurance</b> – Crowns & casts, prosthodontics, endodontics, periodontics, oral surgery	50%	40%
<b>Orthodontic Services Coinsurance</b> (Medically necessary Orthodontic Services only)	50%	50%

]



[

PPO Low Pediatric Dental Plan		
Procedure Categories	In-Network [Network Name]	Out-of-Network
Out-of-Pocket Maximum	\$700 for 1 Child \$1,400 for 2 or more Children	\$700 for 1 Child \$1,400 for 2 or more Children
Annual Deductible – Applies to Preventive, Basic and Major services received In-Network or Out-of-Network	\$50	\$100
Diagnostic & Preventive Services Coinsurance – Exams, cleanings, sealants, fluoride treatment, x-rays	100%	60%
Basic Services Coinsurance – Fillings	55%	40%
Major Services Coinsurance – Crowns & casts, prosthodontics, endodontics, periodontics, oral surgery	35%	20%
Orthodontic Services Coinsurance (Medically necessary Orthodontic Services only)	50%	50%

]

## PART 2 - BENEFITS

### Covered Services

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Certificate.

#### Class I – Preventive and Diagnostic Procedures Include:

- (1) Prophylaxis not more often than once every 6 months;
- (2) Topical application of fluoride (excluding prophylaxis) not more often than twice every 12 months;
- (3) Topical fluoride varnish not more often than twice every 12 months;
- (4) Sealants not more often than once per tooth in a 36-month period and limited to unrestored permanent molars for individuals under age 19;
- (5) Space maintainers, including re-cementation, for individuals under age 19 (excluding removal of fixed space maintainer);
- (6) Periodic oral evaluation not more often than once every 6 months;
- (7) Limited oral evaluation (problem focused) not more often than once every 6 months;
- (8) Comprehensive oral evaluation not more often than once every 6 months;
- (9) Comprehensive periodontal evaluation not more often than once every 6 months;
- (10) Intraoral complete X-rays or panoramic film not more often than once in a 60-month period;
- (11) Bitewing X-rays not more often than one set every 6 months;

- (12) Single film intraoral periapical or occlusal;
- (13) Palliative treatment of dental pain (minor procedure);

**Class II – Basic Procedures Include:**

- (1) Amalgams, resin-based composites, re-cement inlays, re-cement crowns, protective restoration, pin retention;
- (2) Prefabricated stainless steel crowns not more often than once per tooth in a 60-month period for individuals under age 15;
- (3) Therapeutic pulpotomy (excluding restoration) if a root canal is not performed within 45 days of the pulpotomy;
- (4) Partial pulpotomy for apexogenesis limited to permanent tooth with incomplete root development, if a root canal is not performed within 45 days of pulpotomy;
- (5) Pulpal therapy (excluding final restoration) once per tooth per lifetime, limited to primary incisor teeth for individuals up to age 6, and limited to primary molars and cuspids for individuals up to age 11;
- (6) Periodontal scaling and root planning, per quadrant, not more often than once every 24 months;
- (7) Periodontal maintenance not more often than four in a 12-month period, combined with adult prophylaxis after the completion of active periodontal therapy;
- (8) Adjustment and repair of complete or partial dentures;
- (9) Rebase and reline not more often than once in a 36-month period, 6 months after initial installation;
- (10) Tissue conditioning;
- (11) Recement fixed partial denture
- (12) Fixed partial denture repair, by report;
- (13) Oral surgery:
  - a. extraction for erupted tooth or exposed root;
  - b. surgical removal of erupted tooth;
  - c. removal of impacted tooth;
  - d. removal of residual tooth roots;
  - e. coronectomy;
  - f. tooth reimplantation;
  - g. surgical access of unerupted tooth;
  - h. alveoloplasty;
  - i. removal of exostosis;
  - j. incision and drainage of abscess;
  - k. suture of recent small wounds up to 5 cm
  - l. excision of pericoronal gingival;

**Class III – Major Procedures Include:**

- (1) Detailed and extensive oral evaluation;
- (2) Inlays, onlays, crowns, core buildup, including any pins, prefabricated post and core in addition to crown, limited to one per tooth every 60 months;
- (3) Endodontics (root canal)
- (4) Gingivectomy or gingivoplasty, four or more teeth not more often than once every 36 months;
- (5) Gingival flap procedure, four or more teeth not more often than once every 36 months;
- (6) Osseous surgery, four or more contiguous teeth or bounded teeth spaces per quadrant, not more often than once every 36 months;
- (7) Full mouth debridement limited to one per lifetime;
- (8) Complete and partial dentures, including abutments, pontics, onlays, retainers and crowns, not more often than once every 60 months (excludes interim dentures);

- (9) Implants and implant services once every 60 months only if medically necessary;
- (10) Occlusal guard not more often than once in 12 months for individuals 13 and older with predetermination only;
- (11) General anesthesia or IV sedation;
- (12) Consultation by dentist or physician other than the dentist providing treatment;
- (13) Therapeutic drug injection with predetermination;
- (14) Treatment of post-surgical complications with predetermination.

**Class IV – Orthodontic Procedures Include:**

- (1) For orthodontia services associated with the repair of cleft palate and palate or other severe craniofacial defects or injury for which the function of speech, swallowing or chewing is restored;
- (2) Requires predetermination; and
- (3) Coverage includes diagnosis, treatment plan, anticipated treatment time and cost estimate.

**PART 3 - LIMITATIONS AND COST SHARING**

**ACCESS TO CARE**

**Using a Network Provider:**

BEST Life offers Insureds the option to save on out-of-pocket costs when care is provided by a Network Provider. A listing of General Dentists and Specialists is available. To find a Network Provider, please refer to the Network information provided on the ID Card.

**How to Select a Dentist:**

Insureds on this Plan may obtain dental services from any licensed dental professional in the United States. To use the Plan, Insureds may directly contact the dentist of their choice and make an appointment. Insureds are advised to bring their ID Card to their appointment. The dentist may require a copy of the Insured's ID Card to confirm eligibility on this Plan.

**How to Obtain a Referral:**

A dentist may determine that an Insured requires treatment from a dental provider that specializes in a type of dentistry (Specialist). The Insured does not need to contact BEST Life for a referral. The Insured can directly contact the Specialist to make an appointment. The Specialist may require information from the Insured's dentist to determine a treatment plan and may contact the dentist directly.

**ADVANCE NOTICE OF DENTAL TREATMENT**

Subscriber or Insured should submit Advance Notice of Dental Treatment before treatment commences in order to obtain Predetermination of Covered Services, including services that are medically necessary. If dental services are performed without such Predetermination, We reserve the right to deny any claim submitted with respect to such Covered Services; provided however, that predetermination is not required for:

- (1) Covered Services for which the related expense is less than \$500 during any course of treatment ("course of treatment" means one treatment or one of a planned series of treatments resulting from dental examination);
- (2) Emergency treatment; or
- (3) Oral examination and prophylaxis.

Predetermination is required for the following dental services:

- (1) Medically necessary service or supplies;

- (2) Crowns (other than stainless steel);
- (3) Apicoectomy;
- (4) Non-emergency third molar extractions;
- (5) Maxillofacial prosthetics;
- (6) Orthodontia;
- (7) Emergency room services provided by a dentist; and
- (8) Inpatient hospital services.

We will have 30 days to furnish the provider with an Explanation of Benefits demonstrating whether the proposed treatment will be a Covered Service under this Policy.

### **DEDUCTIBLES**

**Annual Deductible:** The Annual Deductible shown in the Schedule of Dental Benefits will apply separately to each Insured. Each Insured must accumulate eligible expenses equal to the deductible amount.

### **ALTERNATIVE PROCEDURES**

If more than one treatment plan exists for a dental procedure, covered dental expenses will be based on the least expensive procedure that will produce a result that meets professionally recognized standards. If the Insured's provider elects the more expensive treatment, the Insured or Subscriber shall be responsible for any charges that are greater than the covered expense for the less expensive treatment.

### **PART 4 – EXCLUSIONS**

The following exclusions are not Covered Services. No payments will be made by Us for these services:

- (1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;
- (2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
- (3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
- (4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;
- (5) Services and supplies started and not completed before the patient was covered under this Plan, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
- (6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
- (7) Space maintainers;
- (8) Sealants if re-sealed within a 5-year period;
- (9) Retreatment of a previous root canal or apicoectomy/periradicular surgery;
- (10) Elective tooth extractions;
- (11) Separate payments for open and drain palliative procedure when the root canal is completed on the same date of service;

- (12) Expenses incurred for gingivectomy or gingivoplasty, periodontal scaling and root planning, full mouth debridement, and periodontal maintenance;
- (13) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are defined as a Covered Dental Expense;
- (14) Charges in excess of Usual, Reasonable and Customary charges amount stated in the "Schedule of Benefits" section of this Plan, or in excess of the Preferred Provider Fee Schedule;
- (15) Charges for service provided for temporomandibular joint dysfunction (TMJ);
- (16) Expenses incurred for congenital or developmental malformations, except as defined as a Covered Orthodontic Expense;
- (17) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits, except as defined as a Covered Orthodontic Expense;
- (18) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
- (19) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, the patient's lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;
- (20) Expenses for services for which the patient would not legally have to pay if there were no insurance, unless mandated by the State;
- (21) Services not completed on or before the date of termination;
- (22) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
- (23) Expenses that are applied toward satisfaction of a Deductible, if any;
- (24) Any service or procedure not commonly found within the scope of practice by a licensed dentist;
- (25) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
- (26) Chemotherapeutic agents and any other experimental procedures;
- (27) Expenses incurred for veneers and related procedures;
- (28) Services and supplies performed outside of the United States of America.

## **PART 5 - DEFINITIONS**

**Annual:** The twelve (12) month period beginning on the effective date of the Certificate and ending on the termination date of the Certificate. The Annual time frame will be applied to the Deductible and the Out-of-Pocket Maximum amount.

**Annual Deductible:** The amount each Insured must satisfy before Benefits are payable by Us. To satisfy the Annual Deductible, the Insured must accumulate expenses for Covered Services equal to the Deductible amount shown on the Schedule of Benefits.

**Certificate Effective Date:** The date shown on the Statement of Coverage as the Certificate Effective Date.

**Child:** A person who is less than 20 years of age on the effective date of the person's coverage.

**Coinsurance:** The amount of an expense for a Covered Service that we will pay once the deductible is satisfied.

**Covered Service:** A service or supply listed as a Covered Service and not otherwise limited or excluded by this Certificate. A Covered Service must be provided by a doctor of medical dentistry or a doctor of dental surgery, or a dentist.

**Eligible Dependent:** A Child, including a natural child, step-child, foster child, lawfully adopted child or child in the process of being adopted from the date of placement, any child for whom the Subscriber has been granted legal custody, or a Child named in a Qualified Medical Child Support Order or other court or administrative order.

**Emergency Care:** A dental emergency where an acute disorder of oral health requires dental and/or medical attention, including broken, loose, or evulsed teeth caused by traumas; infections and inflammations of the soft tissues of the mouth; and complications of oral surgery, such as dry tooth socket.

**Grace Period:** A Grace Period of thirty-one (31) days from the due date will be allowed for payment of each premium after the first. This coverage will remain in effect during the Grace Period; provided the premium is paid before the end of the Grace Period.

**Insured:** Any Eligible Dependent of a Subscriber who is enrolled in and covered under the Policy.

**Medically Necessary:** The determination process that may include, and not limited to, the evaluation of the effectiveness and benefit of a dental service or supply for the individual patient based on scientific evidence considerations, up-to-date and consistent professional standards of care, convincing expert opinion and a comparison to alternative interventions, including interventions, and the cost effectiveness of such service or supply. Medical necessity may be obtained by applying an Advance Notice of Treatment.

**Network Provider:** A dental care professional that is contracted with Us and is part of the Network shown on the Schedule of Benefits.

**Out-of-Network Provider:** A dental care professional that is not a Network Provider.

**Out-of-Pocket Maximum:** The total amount of expenses related to Covered Services, in addition to the Deductible, that must be paid on behalf of an Insured on an Annual basis.

**Plan:** Means any Plan providing benefits or services for or by reason of dental care or treatment, which benefits or services are provided in: (1) group, blanket or franchise insurance coverage; (2) group practice and other group prepayment coverage; (3) group service Plans; (4) any coverage under labor management trustee Plans, union welfare Plans, Employer organization Plans or Employee benefit organization Plans; and (5) any coverage under governmental programs, and any coverage required or provided by any statute. For purposes of coordinating benefits under this Policy, the term "Plan" shall not include any plan of individual coverage or school or church accident type coverages.

The term "Plan" shall be construed separately with respect to each Policy, contract or other arrangement for benefits or services and separately with respect to that portion of such Policy, contract or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

**Statement of Coverage:** The proof of insurance issued to an individual insured under the Policy, outlining the insurance benefits and principle provisions applicable to the member.

**Subscriber:** The person paying premiums to provide coverage on behalf of the Insured; may be the Insured.

**Usual, Reasonable and Customary:** The charge for health care that is consistent with the average rate or charge for identical or similar services in a certain geographical area.

**You or Your:** Means the Insured.

## **PART 6 - COVERAGE EFFECTIVE AND TERMINATION DATES**

### **EFFECTIVE DATE**

**Coverage:** The Insured's coverage will take effect on the Insured's Effective Date as shown on the Statement of Coverage.

### **TERMINATION OF INSURANCE**

The Insured's coverage will stop on the earliest of the following dates:

- (1) the last day of the month in which the Subscriber stops being a member of the Association;
- (2) the last day of the month in which the Insured stops being a member of a class eligible for insurance under this plan;
- (3) the last day of the month in which the Subscriber requests coverage be cancelled;
- (4) the day before the due date of any premium that remains unpaid at the end of the Grace Period;
- (5) the date the Policy terminates;
- (6) the last day of the month in which an Insured stops meeting the definition of Eligible Dependent;
- (7) the day the Insured moves outside of the service area for Insured's selected network. Insured may request a plan change if Insured moves within an area where an alternate plan is available.

BEST Life will notify the Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of this insurance coverage.

## **PART 7 - COORDINATION OF BENEFITS**

**Benefits Subject to this Provision:** All of the benefits provided under the Policy are subject to this provision.

If an Insured is covered by two or more group health insurance policies, the policies may coordinate benefits. Group insurance was designed to cover dental expenses; however, it was never intended to pay in excess of 100% of incurred charges. Coordination of Benefits is established as a method by which two or more carriers or plans could coordinate their respective benefits so the total benefit paid does not exceed 100% of the total allowable expenses incurred.

When there are two or more group carriers involved, one of the carriers is primary and one is secondary. This continues for all carriers involved. The primary carrier pays first, the secondary carrier pays second. This continues for all carriers involved. The order of the carriers is determined, as follows:

**Dependent Children of Non-Separated or Divorced Parents:** The plan covering the parent whose birthday falls earlier in the year is the primary carrier for an Insured under this Certificate. If both parents have the same birthday, the plan that has provided coverage longer is the primary carrier.

**Dependent Children of Separated or Divorced Parents:** The plans must pay in the following order:

- First, the plan of the parent with custody of the child;
- Then, the plan of the spouse or domestic partner of the parent with custody of the child;
- Finally, the plan of the parent not having custody of the child.

However, if terms of a court decree state that one parent is responsible for the health care expenses of the child, and the insurance company has been advised of the responsibility, that plan is primary carrier over the plan of the other parent.

**Dependent Children of Parents With Joint Custody:** The birthday rule applies in this situation.

**Right to Receive and Release Necessary Information:** For the purpose of determining the applicability of and implementing the terms of this provision of this Plan or any provisions of similar purpose of any other Plan, We may, with the consent of any person, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which We deem to be necessary for such purposes. Such information may include information for payment of claims, information to administer your benefits or information to determine medical necessity with our case manager. Any person claiming benefits under this Plan shall furnish to Us such information as may be necessary to implement this provision.

**Facility of Payment:** Whenever payments which should have been made under this Plan in accordance with the Policy have been made under any other Plans, We shall have the right to pay over to any organizations making such other payments any amounts to satisfy our obligation under the policy, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, We shall be fully discharged from liability under this Plan.

**Right to Recovery:** Whenever payments have been made by Us with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, We shall have the right to recover such payments, to the extent of such excess, from among one or more of the following: any persons to or for or with respect to whom such payments are made, any other insurers, service Plans or any other organizations.

## **PART 8 –PREMIUM PROVISIONS**

**Premium Payments:** Renewal premiums are payable to the Company. The payment of any premium shall not continue this Policy in force beyond the next premium due date, except as provided in the Grace Period provision.

**Changes in Premiums:** We may change the amount of the required premium due from the Policyholder by giving the Policyholder at least sixty (60) days advance written notice. During the first 12 months, We will not change the amount of the required premium.

**Grace Period:** This Policy has a thirty-one (31) day Grace Period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following thirty-one (31) days. During the Grace Period, this Policy will remain in force. If the required premium is not paid by the end of this Grace Period, this Policy will lapse as of the end of the Grace Period.



**Termination of Policy:** We may terminate this Policy at any time following the first renewal date by giving the Policyholder written notice at least sixty (60) days in advance. The Policyholder may also terminate this Policy by giving Us written notice at least sixty (60) days before the intended termination date. This Policy will also terminate if the required premium is not paid by the Policyholder as provided in the Grace Period provision.

**Reinstatement:** If any renewal premium is not paid by the end of the Grace Period, coverage under this Policy will be terminated. However, BEST Life will reinstate this Policy, without requiring an application for reinstatement, as long as premium is paid for at least the sixty (60) days prior to the date of reinstatement. The reinstated policy will cover only loss resulting from an accidental injury sustained after the date of reinstatement and loss due to sickness beginning ten (10) days after reinstatement. In all other respects the insured and BEST Life shall have the same rights as they had under the policy immediately before the due date of the defaulted premium, subject to conditions and provisions of the Policy.

## **PART 9 – GENERAL PROVISIONS**

**Clerical Error:** Clerical error by the Policyholder shall not invalidate insurance otherwise validly in force nor continue insurance otherwise validly terminated.

**Third Party Responsibility:** If an Insured is injured or becomes ill through the act or omission of another person, to the extent that the Insured recovers medical expenses for the same Injury or Illness from a third party or its insurer, We will be entitled to a repayment of any remuneration in excess of benefits paid under the Policy due to the same Injury or Illness, and after the Insured is fully compensated for his or her loss. We may file a lien for such repayment. Upon request, the Insured must complete and return the required forms to Us.

The repayment agreement will be binding upon the Insured, or the legal representative of a minor or incompetent, whether:

- (1) the payment received from the third party, or its insurer, is the result of:
  - legal judgment;
  - an arbitration award;
  - a compromise settlement;
  - any other arrangements; or
- (2) the third party or its insurer had admitted liability for the payment; or
- (3) the dental expenses are itemized in the third party payment.

**Entire Contract; Changes:** The policy, including the endorsements, certificates, riders, application and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions. We will consider any statement made by the Insured or the Policyholder, in the absence of fraud, as a representation and not a warranty.

**Underwriting Decisions:** If, for any reason, We cannot accept Your application for coverage, We will communicate Our decision to You in writing with the reasons supporting Our decision.

**Notification to Insureds:** BEST Life will notify Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of your insurance, a change in your premium, a change in eligibility or a change in your benefits. This notice will be given to the appropriate insurance producer and the appropriate administrator, if any, along with non-employee

certificate holders.

**Right to Contest:** After this policy has been in force for a period of two (2) years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application. No claim for loss incurred or disability (as defined in the policy) commencing after two (2) years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

**Notice of Claim:** We must receive written notice within twenty (20) days after a claim starts or as soon as reasonably possible. The notice shall be sent to BEST Life and Health Insurance Company at [2505 McCabe Way, Irvine, California 92614] or given it to Our agent.

**Claim Forms:** When We receive a notice of claim, We will send forms for filing the claim. If the Subscriber or Insured do not receive these forms within fifteen (15) days, the Subscriber or Insured may send Us a written statement to satisfy this requirement. This statement should include the nature and extent of the claim and be sent to Us within the time stated in the Proof of Loss provision.

**Proof of Loss:** We must receive written proof of loss within ninety (90) days of a claim. If it is not possible for proof to be provided within the ninety (90) days, We will not deny a claim for this reason if We receive the proof as soon as possible. In any event, We must receive proof no later than one year from the time specified, unless Subscriber is legally incapacitated.

**Time of Payment of Claims:** Indemnities payable under this Policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this Policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

**Payment of Claims:** All payments will be made to Subscriber or Insured's provider.

**Legal Actions:** A legal action may not be brought against Us before sixty (60) days, or after three (3) years, from the date written proof of loss is required to be given.

**Time Limit on Certain Defenses:** After this Policy has been in force for two (2) years, We will not use any statements made in the application of the Policyholder to void the Policy. After an Insured Person has been covered under this Policy for two (2) years, We will not use any statement made in the Insured Person's enrollment form to defend a claim.

**Misstatement of Age:** If the age of any individual covered under the Policy has been misstated, there shall be an adjustment of premium for the Policy so that there shall be paid to Us the premium for the coverage of such individual at his or her correct age, and the amount of the insurance coverage shall not be affected.

**Worker's Compensation:** The Policy is not in lieu of and does not affect any requirement for coverage by Worker's Compensation Insurance.

**Conformity with State Statutes:** Any provisions of the Policy which are in conflict with the statutes of the

state in which the Policy was issued or delivered will be changed to conform to such laws.

**Waiver of Rights:** If We fail to enforce any provision of the Policy, such failure will not affect Our right to do so at a later date, nor will it affect Our right to enforce any other provision of the Policy.

**Inspection of Policy:** The Policy is in the possession of the Policyholder. It may be inspected at any time during business hours at the office of the Policyholder.

**Duty to Cooperate:** As a condition precedent to the payment of benefits hereunder, the Subscriber and Insured are required to cooperate with Us by providing all information reasonably required to accurately process a claim. Any failure to provide necessary information may result in a denial of benefits for the claim.

## **PART 10 – FILING A DENTAL CLAIM**

**HOW TO FILE A CLAIM:** Claim forms may be obtained from [the BEST Life website located at [www.bestlife.com](http://www.bestlife.com), click on “Forms”].

Submit claims to [BEST Life and Health Insurance Company], [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

For questions about a claim payment, contact BEST Life’s Customer Service at [1-800-433-0088 or at [cs@bestlife.com](mailto:cs@bestlife.com), Monday through Friday, 7 am to 5 pm Pacific Time].

**CLAIMS DENIAL PROCEDURE:** Any denial of a claim for Benefits will be explained in writing. The explanation will include (a) the specific reason for the denial, (b) reference to the plan provision upon which the denial was based, (c) a description of any additional information that might be required to provide and an explanation of why it is needed, and (d) an explanation of the plan's claim review procedure.

**APPEALING THE DENIAL OF A CLAIM:** You or an authorized representative You appoint to assist or represent You, may appeal any denial of a claim, in whole or in part, for Benefits by filing a written request for a review. The request must include all reasons You believe the initial decision was incorrect and all documentation supporting Your appeal, to BEST Life and Health Insurance Company, Attn: Appeals, [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

A request for a review must be filed within one-hundred and eighty (180) days after the date on which we issue the written notice of denial of a claim. BEST Life and Health Insurance Company will provide an appeal determination not later than sixty (60) days after receipt of a request for review. If there are special circumstances, the decision will be made as soon as possible, but no later than fifteen (15) days after receipt of the request for review. The appeal determination will be in writing and will include specific reasons for the decision. This decision shall also include specific references to the Policy provisions on which the decision was based.

**Underwritten by BEST Life and Health Insurance Company**

## VARIABILITY STATEMENT

GPD-IM-PPO-POL-0113TN

**Title Page** – The address and officers of the company may change; Policy.

**Page 2** – The President and Secretary of the company may change.

**Page 3** – Specific to the Client.

**Policyholder** – Is the BEST Employers Association. Is bracketed to allow this product to be offered to other Associations.

**Schedule of Benefits** – we are offering two plan designs. We have provided the full range of possibilities that would apply. In the final Certificate, only the plan that was selected will appear.

### General Provisions

- **Notice of Claim** – Address may change.

### Filing a Dental Claim

- How to file a claim – URLs and contact information are bracketed to allow for changes, and possibly a third party administrator. Right now, there is no contract with a third party administrator, so BEST Life's current contact information is provided.
- Appealing the denial of a claim – address may change.

GPD-IM-PPO-CERT-0113TN

**Title Page** –The address of the company may change.

**Page 2** – The President and Secretary of the company may change.

**Statement of Coverage** – Group and Insured information will be provided in the bracketed fields.

- **Subscriber Name** – Specific to individual purchasing the plan.
- **Certificate Effective Date** – Specific to the plan year for the Exchange.
- **Insured name(s) and Effective Dates(s)** – specific to client.
- **Participating employer name and number** – specific to the client.
- **Plan information** – We are transitioning to a new administrative system. Our current administrative system provides plan selection information in the Statement of Coverage. The new administrative system will provide this information in the Schedule of Benefits. The Plan, Deductible, and Annual Maximum is bracketed because these fields will no longer be provided once the new system is up and running.
- **Group Policy Number** – Specific to the client.

**Policyholder** – Is the BEST Employers Association. Is bracketed to allow this product to be offered to other Associations.

**Schedule of Benefits** – we are offering two plan designs. We have provided the full range of possibilities that would apply. In the final Certificate, only the plan that was selected will appear.

**General Provisions**

- **Notice of Claim** – Address may change.

**Filing a Dental Claim**

- How to file a claim – URLs and contact information are bracketed to allow for changes, and possibly a third party administrator. Right now, there is no contract with a third party administrator, so BEST Life's current contact information is provided.
- Appealing the denial of a claim – address may change.

**Individually Underwritten  
Association Insurance Policy**

**Dental PPO Plan**



[2505 McCabe Way  
Irvine, California 92614]

**Notice to Buyer: This Policy provides dental coverage only.**

**BEST Life and Health Insurance Company**  
[2505 McCabe Way  
Irvine, California 92614]

A STOCK COMPANY  
(Herein called the Company)

**BEST Life and Health Insurance Company**, in consideration of the application of the Subscribing Employer and the payment of premiums as due, agrees, subject to the terms and conditions of this Group Policy, to insure Eligible Employees of Subscribing Employers to the Group Policyholder and their eligible Dependents under this Group Policy.

**GOVERNING JURISDICTION:** The Group Policy is issued in the State of California. Its terms are governed by and shall be construed in accordance with the laws of the Governing Jurisdiction.

This Group Policy becomes effective at 12:01 a.m., Standard Time at the office of the Group Policyholder on the Group Policy Effective Date in the State of Delivery specified below. Subject to the terms and conditions of this Group Policy, it can be renewed until the First Renewal Date by timely payment of the required premium by the Group Policyholder. Unless terminated in accordance with the applicable provision of this Group Policy, it can be renewed after such time from month to month, subject to the terms and conditions of this Group Policy, by timely payment of the required premium.

**NOTICE OF TEN DAY RIGHT TO EXAMINE:** We want You to fully understand and be satisfied with the insurance coverage. If for any reason You are not satisfied, You may return this Group Policy to the agent or to Our home office within ten days of receipt and the premium will be fully refunded. Coverage will then be void retroactive to the Insurance Effective Date.

This Group Policy may be modified by mutual agreement between the Group Policyholder and Us.

The provisions and the terms in the Certificate are part of this Group Policy. A copy of the Certificate is attached to, and made a part of this Group Policy.

Signed for **BEST Life and Health Insurance Company** by its President and Secretary at [2505 McCabe Way, Irvine, California 92614.]

[ 

President

II



Secretary

**Group PPO**  
**Pediatric Dental Policy**  
Non-Participating



**Group Policyholder:** BEST Employers Association

**Group Policy Effective Date:** [XX-XX-XXXX]

**Group Policy Number:** [XXX]

**State of Delivery:** California

**Premiums Due On:** 1<sup>st</sup> of each month

**First Renewal Date:** [XX-XX-XXXX]

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## PART 1 - SCHEDULE OF BENEFITS

This Certificate of Group Coverage is made valid on the effective dates shown for the listed Insureds on the Statement of Coverage.

The Policy is issued by **BEST Life and Health Insurance Company** to: [BEST Employers Association].

Covered Services received by Insured from a Network Provider are reimbursed at the Network Provider's contracted Fee Schedule. Covered Services received by Insured from an Out-of-Network Provider are reimbursed at the [80th or 90th] percentile of a Usual, Reasonable and Customary schedule. All Covered Services are subject to Cost Sharing as shown on this Schedule of Benefits.

[

Benefits Description	[PPO Dental High] Plan	
	In-Network [Network]	Out-of-Network
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Annual Maximum	\$[1,000 – 1,500]	
Annual Deductible (Applies to Basic and Major) – 3 Deductible Maximum per Family	\$50	
<b>Preventive Care Services</b> Routine oral exam, cleanings, X-rays	100%	100%
<b>Basic Services</b> Filings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology	90%	80%
<b>Major Services</b> Crowns & gold filings, inlays, onlays & pontics, implants, fixed bridges, complete & partial dentures	60%	50%
Major Services Waiting Period	12 Months	
Endodontic Services	Basic	
Periodontic Services	Major	
Oral Surgery Services	Major	
Dental Accident Benefit	\$1,000	
<b>Child Orthodontic Coverage</b> Orthodontic Services Coinsurance Orthodontic Maximums – Calendar Year   Lifetime 12 Month Waiting Period	50% \$500   \$1,000	
Usual and Customary Reimbursement	Fee Schedule	80 <sup>th</sup> Percentile

]

[

[PPO Dental Mid] Plan		
Benefits Description	In-Network [Network]	Out-of-Network
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Annual Maximum	\$1,500	
Annual Deductible (Applies to Basic and Major) – 3 Deductible Maximum per Family	\$50	
<b>Preventive Care Services</b> Routine oral exam, cleanings, X-rays	100%	80%
<b>Basic Services</b> Filings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology	80%	80%
<b>Major Services</b> Crowns & gold filings, inlays, onlays & pontics, implants, fixed bridges, complete & partial dentures	50%	50%
<b>Major Services Waiting Period</b>	12 Months	
<b>Endodontic Services</b>	Major	
<b>Periodontic Services</b>	Major	
<b>Oral Surgery Services</b>	Major	
<b>Dental Accident Benefit</b>	\$1,000	
<b>Child Orthodontic Coverage</b> Orthodontic Services Coinsurance Orthodontic Maximums – Calendar Year   Lifetime 12 Month Waiting Period	50% \$500   \$1,000	
<b>Usual and Customary Reimbursement</b>	Fee Schedule	80 <sup>th</sup> Percentile

]

[

[PPO Dental Basic] Plan		
Benefits Description	In-Network [Network]	Out-of-Network
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Annual Maximum	\$1,000	
Annual Deductible (Applies to Basic and Major) – 3 Deductible Maximum per Family	\$50	
<b>Preventive Care Services</b> Routine oral exam, cleanings, X-rays	100%	80%
<b>Basic Services</b> Filings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology	80%	50%
<b>Major Services</b> Crowns & gold filings, inlays, onlays & pontics, implants, fixed bridges, complete & partial dentures	0%	0%
<b>Endodontic Services</b>	Major	
<b>Periodontic Services</b>	Major	
<b>Oral Surgery Services</b>	Major	
<b>Dental Accident Benefit</b>	\$1,000	
<b>Usual and Customary Reimbursement</b>	Fee Schedule	80 <sup>th</sup> Percentile

]
 [

	[PPO Dental Value] Plan	
Benefits Description	In-Network [Network]	Out-of-Network
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Annual Maximum	\$1,000	
Annual Deductible (Applies to Basic and Major) – 3 Deductible Maximum per Family	\$50	
<b>Preventive Care Services</b> Routine oral exam, cleanings, X-rays	100%	80%
<b>Basic Services</b> Fillings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology	50%	20%
<b>Major Services</b> Crowns & gold fillings, inlays, onlays & pontics, implants, fixed bridges, complete & partial dentures	0%	0%
<b>Endodontic Services</b>	Major	
<b>Periodontic Services</b>	Major	
<b>Oral Surgery Services</b>	Major	
<b>Dental Accident Benefit</b>	\$1,000	
<b>Usual and Customary Reimbursement</b>	Fee Schedule	80 <sup>th</sup> Percentile

]

## PART 2 - BENEFITS

### Covered Services

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Certificate.

#### CLASS I - Preventive Dental Procedures include:

- (1) Routine oral examination and diagnosis not more often than twice every 12 months per individual;
- (2) Bitewing x-rays not more often than once every 12 months per individual;
- (3) Full mouth x-rays or panoramic films are limited to once every five years; any combination of eight or more x-rays (including but not limited to bitewings or periapicals/intraorals) will be combined into a full mouth x-ray series;
- (4) Prophylaxis not more often than once every six months per individual.

#### CLASS II - Basic Dental Procedures include:

- (1) Pathology;
- (2) All fillings other than lab fabricated restorations (composite fillings limited to permanent anterior and posterior teeth);
- (3) Emergency palliative treatment;
- (4) Limited oral exam not more than once every six months;
- (5) Simple extraction, excluding orthodontic extractions unless a orthodontic benefits are a Covered Dental Expense on this Plan;
- (6) Surgical extraction, including impaction:

- (a) erupted tooth;
- (b) soft tissue impaction;
- (c) partial bony impaction;
- (d) complete bony impaction;
- (7) General anesthesia or intravenous sedation when required for complex oral surgical procedures (partial and complete bony impacted extractions only);
- (8) Periodontics (tissues and gums);
- (9) Periodontal exam (not in addition to a routine oral exam);
- (10) Periodontal maintenance (limited to once every six months per individual following active periodontal treatment) and not on the same visit as a routine prophylaxis;
- (11) Periodontal scaling and root planing (limited to once every 36 months and to two quadrants per visit, and not in addition to a routine prophylaxis);
- (12) Endodontics (pulp capping and root canal); and
- (13) Oral surgery:
  - (a) root recovery (surgical removal of residual root);
  - (b) oral antral fistula closure;
  - (c) removal of a dentigerous or odontogenic cyst;
  - (d) incision and drainage of an abscess;
  - (e) removal of lateral exostosis;
  - (f) frenulectomy.

[**Note:** Unless the twelve (12) month waiting period requirement for Major Dentistry services has been met, the services below are not covered benefits for any treatment that began during the twelve (12) month period immediately following Your effective date of coverage.]

**CLASS III - Major Dental Procedures include:**

- (1) Inlays, onlays, crowns and other lab fabricated restorations (not including veneers);
- (2) Porcelain, porcelain fused to metal, or full gold crowns on permanent teeth;
- (3) Full or partial dentures or fixed bridgework or adding teeth to an existing denture, if required because of loss of functional natural teeth while the person is covered for this Benefit. The work must be done within 12 months after the extraction and while this coverage is in force;
- (4) Replacement or alteration of full or partial dentures or fixed bridgework caused by the following while coverage is in force:
  - (a) accidental injury requiring oral surgical treatment, or
  - (b) oral surgical treatment involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus or redundant tissue, provided the replacement or alteration is done within 12 months of the injury or surgical treatment.
- (5) Replacement of a full denture or bridgework if the replacement is made more than seven years after the date of installation, unless:
  - (a) such replacement is made necessary by the initial extraction of an adjoining functional natural tooth; or
  - (b) the prosthesis, while in the oral cavity, has been damaged beyond repair as a result of a non-chewing injury while covered;
- (6) Repair or reline of dentures and bridgework;
- (7) Implants, as an alternative to a fixed prosthetic, (limited to once in a lifetime per site). The cost of the fixed prosthetic will be applied to the total value of the implant and implant-related procedures, not to exceed the cost of the fixed prosthetic:
  - (a) the surgical placement of endosteal implant body including healing cap, where the bone and soft tissues are sound and healthy;
  - (b) implant supported prosthetics;
  - (c) eposteal and transosteal implants will be covered at the cost of the endosteal implant (if

- performed, member is responsible for additional fees);
- (d) bone grafting and tooth extractions, provided the work is done while this coverage is in force;
- (e) implant maintenance.

[**Note:** Unless the twelve (12) month waiting period requirement for Orthodontic Procedures has been met, the services below are not covered benefits for any treatment that begin during the twelve (12) month period immediately following Your effective date of coverage.]

**[CLASS IV – Orthodontic Procedures Include:**

Provides orthodontic treatment for Dependent children until the end of the month of their 18<sup>th</sup> birthday, to be payable as follows:

- (1) All procedures performed in connection with orthodontic treatment subject to the coinsurance level, Calendar Year and Lifetime Maximum Benefit as defined in the Schedule of Benefits;
- (2) Benefits for the initial placement up to [1/3][1/2] of the Lifetime Maximum Benefit Amount, as an initial down payment;
- (3) Periodic follow-up visits will be payable on a monthly basis during the scheduled course of orthodontic treatment, up to the Lifetime Maximum Amount;
- (4) Orthodontic benefits end once braces are removed or at the cancellation of coverage, whichever comes first.]

**Supplemental Dental Accident Benefit**

This benefit provides 100% coverage, not subject to deductible or coinsurance, for injury to sound, natural teeth up to a maximum benefit amount of \$1,000. Predetermination must be submitted before benefits are payable.

**PART 3 - LIMITATIONS AND COST SHARING**

**ACCESS TO CARE**

**Using a Network Provider:**

BEST Life offers Insureds the option to save on out-of-pocket costs when care is provided by a Network Provider. A listing of General Dentists and Specialists is available. To find a Network Provider, please refer to the Network information provided on the ID Card.

**How to Select a Dentist:**

Insureds on this Plan may obtain dental services from any licensed dental professional in the United States. To use the Plan, Insureds may directly contact the dentist of their choice and make an appointment. Insureds are advised to bring their ID Card to their appointment. The dentist may require a copy of the Insured's ID Card to confirm eligibility on this Plan.

**How to Obtain a Referral:**

A dentist may determine that an Insured requires treatment from a dental provider that specializes in a type of dentistry (Specialist). The Insured does not need to contact BEST Life for a referral. The Insured can directly contact the Specialist to make an appointment. The Specialist may require information from the Insured's dentist to determine a treatment plan and may contact the dentist directly.

**ADVANCE NOTICE OF DENTAL TREATMENT**

Subscriber or Insured should submit Advance Notice of Dental Treatment before treatment



commences in order to obtain Predetermination of Covered Services, including services that are medically necessary. If dental services are performed without such Predetermination, We reserve the right to deny any claim submitted with respect to such Covered Services; provided however, that predetermination is not required for:

- (1) Covered Services for which the related expense is less than \$500 during any course of treatment ("course of treatment" means one treatment or one of a planned series of treatments resulting from dental examination);
- (2) Emergency treatment; or
- (3) Oral examination and prophylaxis.

Predetermination is required for the following dental services:

- (1) Crowns, Anterior, except with posts or root canal;
- (2) Crowns, two (2) or more Posterior, except with posts or root canal;
- (3) Inlays or Onlays, two (2) or more, except with posts or root canal;
- (4) Laminates;
- (5) Anterior composites;
- (6) Two (2) or more multiple surfaces;
- (7) Bridges – initial or replacement;
- (8) Eligible partial dentures – initial or replacement;
- (9) Periodontal surgery over \$500;
- (10) Full bony impactions, two (2) or more.

We will have thirty (30) days to furnish the provider with an Explanation of Benefits demonstrating whether the proposed treatment will be a Covered Service under this Policy.

## **DEDUCTIBLES**

**Annual Deductible:** The Annual Deductible shown in the Schedule of Dental Benefits will apply separately to each Insured. Each Insured must accumulate eligible expenses equal to the deductible amount.

## **ALTERNATIVE PROCEDURES**

If more than one treatment plan exists for a dental procedure, covered dental expenses will be based on the least expensive procedure that will produce a result that meets professionally recognized standards. If the Insured's provider elects the more expensive treatment, the Insured or Subscriber shall be responsible for any charges that are greater than the covered expense for the less expensive treatment.

## **PART 4 – EXCLUSIONS**

The following exclusions are not Covered Services. No payments will be made by Us for these services:

- (1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;
- (2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
- (3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
- (4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses

- incurred due to treatment rendered by Your employer;
- (5) Services and supplies begun and not completed prior to the patient's effective date, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
  - (6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
  - (7) Pulp capping, if in conjunction with the installation of inlays, onlays or crowns and fillings or other lab fabricated restorations; including but not limited to inlays, onlays and crowns, preventative tests and examinations diagnostic casts and oral cancer screenings, and expenses incurred for sedative fillings, including charges for prescribed drugs, pre-medication or analgesia;
  - (8) The initial installation of a prosthetic device (a fixed bridge, implant, or denture), including crowns and inlays which form abutments, to replace teeth missing before You were covered under the Policy, except when it also replaces a tooth that is extracted while covered unless such installation commences after You have remained continuously covered under this plan for at least three years immediately prior to the date such installation commences;
  - (9) Implants, implant services and implant supported prosthetics are not covered for patients under the age of 16;
  - (10) Expenses incurred for veneers and related procedures;
  - (11) Replacement of a lost or stolen or discarded prosthetic device;
  - (12) Adjustment, repairs or relines of prostheses for a period of one year from initial placement if the prostheses were paid for under this plan;
  - (13) Expenses incurred for a core buildup will only be considered in conjunction with a crown;
  - (14) If multiple endodontic treatments are necessary on the same tooth within a period of one year, the allowance will be made for only one procedure;
  - (15) X-rays are considered an integral part of the endodontic procedure rather than a separate service and are therefore not eligible for benefits;
  - (16) The extraction of immature erupting third molars and non-pathologic, asymptomatic third molar extractions;
  - (17) Expenses for gross debridement allowed one time at the beginning of the periodontal treatment plan prior to pocket depth charting;
  - (18) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
  - (19) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are a Covered Dental Expense on this Plan;
  - (20) Surgical procedures incidental to orthodontic treatment, including but not limited to, extraction of teeth solely for orthodontic reasons, exposure of impacted teeth, correction of micrognathia or macrognathia, or repair of cleft palate;
  - (21) Charges for service provided for temporomandibular joint dysfunction (TMJ);
  - (22) Expenses incurred for congenital or developmental malformations;
  - (23) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
  - (24) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits;
  - (25) Chemotherapeutic agents and any other experimental procedures;
  - (26) Charges in excess of Usual, Reasonable and Customary charges or in excess of the Calendar Year Maximum amount stated in the "Schedule of Dental Benefits" section of this Plan, or in excess of the Preferred Provider Fee Schedule;
  - (27) Expenses that are applied toward satisfaction of a Deductible, if any;
  - (28) Services and supplies performed outside of the United States of America;

- (29) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, Your lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;
- (30) Expenses for services for which You would not legally have to pay if there were no insurance;
- (31) Services not completed on or before the date of termination;
- (32) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
- (33) Any service or procedure not commonly found within the scope of practice by a licensed dentist. Such procedures are identified within the current Common Dental Terminology (CDT Codes) published by the American Dental Association;
- (34) Expenses incurred for services covered on a pediatric only dental plan.

## **PART 5 - DEFINITIONS**

**Annual:** The twelve (12) month period beginning on the effective date of the Certificate and ending on the termination date of the Certificate. The Annual time frame will be applied to the Deductible and the Annual Maximum amount.

**Annual Deductible:** The amount each Insured must satisfy before Benefits are payable by Us. To satisfy the Annual Deductible, the Insured must accumulate expenses for Covered Services equal to the Deductible amount shown on the Schedule of Benefits.

**Annual Maximum:** The maximum amount BEST Life will reimburse for covered services during a twelve (12) month period for each Insured person. Once the full Annual Maximum amount has been paid, no additional services will be reimbursed for the remainder of that year. The

**Certificate Effective Date:** The date shown on the Statement of Coverage as the Certificate Effective Date.

**Coinsurance:** The amount of an expense for a Covered Service that we will pay once the deductible is satisfied.

**Covered Service:** A service or supply listed as a Covered Service and not otherwise limited or excluded by this Certificate. A Covered Service must be provided by a doctor of medical dentistry or a doctor of dental surgery, or a dentist.

**Eligible Dependent:** Means:

- (1) Your lawful spouse or domestic partner and
- (2) Your or Your spouse's or domestic partner's child or children, including a natural child, step-child, foster child, lawfully adopted child or child in the process of being adopted, from the date of placement, or any child for whom You have been granted legal custody, provided they are [less than][between 20 and] 26 years of age; or
- (3) A child named in a Qualified Medical Child Support Order will be considered a dependent.

"Eligible Dependent" also means a dependent child, who upon reaching the termination age, is unable to sustain employment because of a permanent mental or physical handicap and You notify Us in writing within thirty-one (31) days after the termination age, the child will continue to qualify as a dependent under this plan, provided You and the dependent child continue to be insured under this plan, and the child continues to be handicapped and dependent upon You for support. This shall not

apply to a dependent child who is beyond the termination age on the date You become eligible for dependent insurance under this Policy.

**Family Deductible:** The Family Deductible is satisfied when each of three (3) covered members of Your family satisfy the Annual Deductible. Once the combined costs of services provided by covered members of Your family is equal to the Family Deductible amount, no additional Deductible will be required for other insured family members for the remainder of the Calendar Year.

**Emergency Care:** A dental emergency where an acute disorder of oral health requires dental and/or medical attention, including broken, loose, or evulsed teeth caused by traumas; infections and inflammations of the soft tissues of the mouth; and complications of oral surgery, such as dry tooth socket.

**Grace Period:** A Grace Period of thirty-one (31) days from the due date will be allowed for payment of each premium after the first. This coverage will remain in effect during the Grace Period; provided the premium is paid before the end of the Grace Period.

**Insured:** The Subscriber or any Eligible Dependent of a Subscriber who is enrolled in and covered under the Policy.

**Network Provider:** A dental care professional that is contracted with Us and is part of the Network shown on the Schedule of Benefits.

**Out-of-Network Provider:** A dental care professional that is not a Network Provider.

**Plan:** Means any Plan providing benefits or services for or by reason of dental or treatment, which benefits or services are provided in: (1) group, blanket or franchise insurance coverage; (2) group practice and other group prepayment coverage; (3) group service Plans; (4) any coverage under labor management trustee Plans, union welfare Plans, Employer organization Plans or Employee benefit organization Plans; and (5) any coverage under governmental programs, and any coverage required or provided by any statute. For purposes of coordinating benefits under this Policy, the term "Plan" shall not include any plan of individual coverage or school or church accident type coverages.

The term "Plan" shall be construed separately with respect to each Policy, contract or other arrangement for benefits or services and separately with respect to that portion of such Policy, contract or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

**Statement of Coverage:** The proof of insurance issued to an individual insured under the Policy, outlining the insurance benefits and principle provisions applicable to the member.

**Subscriber:** The primary insured person as shown on the Statement of Coverage.

**Usual, Reasonable and Customary:** The charge for health care that is consistent with the average rate or charge for identical or similar services in a certain geographical area.

**You or Your:** Means the Insured.

## **PART 6 - COVERAGE EFFECTIVE AND TERMINATION DATES**

## EFFECTIVE DATE

**Coverage:** The Insured's coverage will take effect on the Insured's Effective Date as shown on the Statement of Coverage.

## TERMINATION OF INSURANCE

The Insured's coverage will stop on the earliest of the following dates:

- (1) the last day of the month in which the Subscriber stops being a member of the Association;
- (2) the last day of the month in which the Insured stops being a member of a class eligible for insurance under this plan;
- (3) the last day of the month in which the Subscriber requests coverage be cancelled;
- (4) the day before the due date of any premium that remains unpaid at the end of the Grace Period;
- (5) the date the Policy terminates;
- (6) the last day of the month in which an Insured stops meeting the definition of Eligible Dependent; or
- (7) the day the Insured moves outside of the service area for Insured's selected network. Insured may request a plan change if Insured moves within an area where an alternate plan is available.

BEST Life will notify Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of this insurance coverage.

## PART 7 – COORDINATION OF BENEFITS

**Benefits Subject to this Provision:** All of the benefits provided under the Policy are subject to this provision.

If an Insured is covered by two or more group health insurance policies, the policies may coordinate benefits. Group insurance was designed to cover dental expenses; however, it was never intended to pay in excess of 100% of incurred charges. Coordination of Benefits is established as a method by which two or more carriers or plans could coordinate their respective benefits so the total benefit paid does not exceed 100% of the total allowable expenses incurred.

When there are two or more group carriers involved, one of the carriers is primary and one is secondary. This continues for all carriers involved. The primary carrier pays first, the secondary carrier pays second. This continues for all carriers involved. The order of the carriers is determined, as follows:

**Dependent Children of Non-Separated or Divorced Parents:** The plan covering the parent whose birthday falls earlier in the year is the primary carrier for an Insured under this Certificate. If both parents have the same birthday, the plan that has provided coverage longer is the primary carrier.

**Dependent Children of Separated or Divorced Parents:** The plans must pay in the following order:

- First, the plan of the parent with custody of the child;
- Then, the plan of the spouse or domestic partner of the parent with custody of the child;
- Finally, the plan of the parent not having custody of the child.

However, if terms of a court decree state that one parent is responsible for the health care expenses of the child, and the insurance company has been advised of the responsibility, that plan is primary carrier over the plan of the other parent.

**Dependent Children of Parents With Joint Custody:** The birthday rule applies in this situation.

**Right to Receive and Release Necessary Information:** For the purpose of determining the applicability of and implementing the terms of this provision of this Plan or any provisions of similar purpose of any other Plan, We may, with the consent of any person, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which We deem to be necessary for such purposes. Such information may include information for payment of claims, information to administer your benefits or information to determine medical necessity with our case manager. Any person claiming benefits under this Plan shall furnish to Us such information as may be necessary to implement this provision.

**Facility of Payment:** Whenever payments which should have been made under this Plan in accordance with the Policy have been made under any other Plans, We shall have the right to pay over to any organizations making such other payments any amounts to satisfy our obligation under the Policy, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, We shall be fully discharged from liability under this Plan.

**Right to Recovery:** Whenever payments have been made by Us with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, We shall have the right to recover such payments, to the extent of such excess, from among one or more of the following: any persons to or for or with respect to whom such payments are made, any other insurers, service Plans or any other organizations.

## **PART 8 –PREMIUM PROVISIONS**

**Premium Payments:** Renewal premiums are payable to the Company. The payment of any premium shall not continue this Policy in force beyond the next premium due date, except as provided in the Grace Period provision.

**Changes in Premiums:** We may change the amount of the required premium due from the Policyholder by giving the Policyholder at least sixty (60) days advance written notice. During the first 12 months, We will not change the amount of the required premium.

**Grace Period:** This Policy has a thirty-one (31) day Grace Period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following thirty-one (31) days. During the Grace Period, this Policy will remain in force. If the required premium is not paid by the end of this Grace Period, this Policy will lapse as of the end of the Grace Period.

**Termination of Policy:** We may terminate this Policy at any time following the first renewal date by giving the Policyholder written notice at least sixty (60) days in advance. The Policyholder may also terminate this Policy by giving Us written notice at least sixty (60) days before the intended termination date. This Policy will also terminate if the required premium is not paid by the Policyholder as provided in the Grace Period provision.

**Reinstatement:** If any renewal premium is not paid by the end of the Grace Period, coverage under this Policy will be terminated. However, BEST Life will reinstate this Policy, without requiring an application for reinstatement, as long as premium is paid for at least the sixty (60) days prior to the date of reinstatement. The reinstated Policy will cover only loss resulting from an accidental injury sustained after the date of reinstatement and loss due to sickness beginning ten (10) days after reinstatement. In all other respects the insured and BEST Life shall have the same rights as they had under the Policy immediately before

the due date of the defaulted premium, subject to conditions and provisions of the Policy.

## **PART 9 – GENERAL PROVISIONS**

**Clerical Error:** Clerical error by the Policyholder shall not invalidate insurance otherwise validly in force nor continue insurance otherwise validly terminated.

**Third Party Responsibility:** If an Insured is injured or becomes ill through the act or omission of another person, to the extent that the Insured recovers medical expenses for the same Injury or Illness from a third party or its insurer, We will be entitled to a repayment of any remuneration in excess of benefits paid under the Policy due to the same Injury or Illness, and after the Insured is fully compensated for his or her loss. We may file a lien for such repayment. Upon request, the Insured must complete and return the required forms to Us.

The repayment agreement will be binding upon the Insured, or the legal representative of a minor or incompetent, whether:

- (1) the payment received from the third party, or its insurer, is the result of:
  - legal judgment;
  - an arbitration award;
  - a compromise settlement;
  - any other arrangements; or
- (2) the third party or its insurer had admitted liability for the payment; or
- (3) the medical expenses are itemized in the third party payment.

**Entire Contract; Changes:** The Policy, including the endorsements, certificates, riders, application and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions. We will consider any statement made by the Insured or the Policyholder, in the absence of fraud, as a representation and not a warranty.

**Underwriting Decisions:** If, for any reason, We cannot accept Your application for coverage, We will communicate Our decision to You in writing with the reasons supporting Our decision.

**Notification to Insureds:** BEST Life will notify Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of your insurance, a change in your premium, a change in eligibility or a change in your benefits. This notice will be given to the appropriate insurance producer and the appropriate administrator, if any, along with non-employee certificate holders.

**Right to Contest:** After this Policy has been in force for a period of two (2) years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application. No claim for loss incurred or disability (as defined in the Policy) commencing after two (2) years from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Policy.

**Notice of Claim:** We must receive written notice within twenty (20) days after a claim starts or as soon as reasonably possible. The notice shall be sent to BEST Life and Health Insurance Company at

[2505 McCabe Way, Irvine, California 92614] or given it to Our agent.

**Claim Forms:** When We receive a notice of claim, We will send forms for filing the claim. If the Subscriber or Insured do not receive these forms within fifteen (15) days, the Subscriber or Insured may send Us a written statement to satisfy this requirement. This statement should include the nature and extent of the claim and be sent to Us within the time stated in the Proof of Loss provision.

**Proof of Loss:** We must receive written proof of loss within ninety (90) days of a claim. If it is not possible for proof to be provided within the ninety (90) days, We will not deny a claim for this reason if We receive the proof as soon as possible. In any event, We must receive proof no later than one year from the time specified, unless Subscriber is legally incapacitated.

**Time of Payment of Claims:** Indemnities payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this Policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

**Payment of Claims:** All payments will be made to Subscriber or Insured's provider.

**Legal Actions:** A legal action may not be brought against Us before sixty (60) days, or after three (3) years, from the date written proof of loss is required to be given.

**Time Limit on Certain Defenses:** After this Policy has been in force for two (2) years, We will not use any statements made in the application of the Policyholder to void the Policy. After an Insured Person has been covered under this Policy for two (2) years, We will not use any statement made in the Insured Person's enrollment form to defend a claim.

**Misstatement of Age:** If the age of any individual covered under the Policy has been misstated, there shall be an adjustment of premium for the Policy so that there shall be paid to Us the premium for the coverage of such individual at his or her correct age, and the amount of the insurance coverage shall not be affected.

**Worker's Compensation:** The Policy is not in lieu of and does not affect any requirement for coverage by Worker's Compensation Insurance.

**Conformity with State Statutes:** Any provisions of the Policy which are in conflict with the statutes of the state in which the Policy was issued or delivered will be changed to conform to such laws.

**Waiver of Rights:** If We fail to enforce any provision of the Policy, such failure will not affect Our right to do so at a later date, nor will it affect Our right to enforce any other provision of the Policy.

**Inspection of Policy:** The Policy is in the possession of the Policyholder. It may be inspected at any time during business hours at the office of the Policyholder.

**Duty to Cooperate:** As a condition precedent to the payment of benefits hereunder, the Subscriber and Insured are required to cooperate with Us by providing all information reasonably required to accurately process a claim. Any failure to provide necessary information may result in a denial of benefits for the



claim.

## **PART 10 – FILING A DENTAL CLAIM**

**HOW TO FILE A CLAIM:** Claim forms may be obtained from [the BEST Life website located at [www.bestlife.com](http://www.bestlife.com), click on “Forms”].

Submit claims to [BEST Life and Health Insurance Company], [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

For questions about a claim payment, contact BEST Life’s Customer Service at [1-800-433-0088 or at [cs@bestlife.com](mailto:cs@bestlife.com), Monday through Friday, 7 am to 5 pm Pacific Time].

**CLAIMS DENIAL PROCEDURE:** Any denial of a claim for Benefits will be explained in writing. The explanation will include (a) the specific reason for the denial, (b) reference to the plan provision upon which the denial was based, (c) a description of any additional information that might be required to provide and an explanation of why it is needed, and (d) an explanation of the plan's claim review procedure.

**APPEALING THE DENIAL OF A CLAIM:** You or an authorized representative You appoint to assist or represent You, may appeal any denial of a claim, in whole or in part, for Benefits by filing a written request for a review. The request must include all reasons You believe the initial decision was incorrect and all documentation supporting Your appeal, to BEST Life and Health Insurance Company, Attn: Appeals, [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

A request for a review must be filed within one-hundred and eighty (180) days after the date on which we issue the written notice of denial of a claim. BEST Life and Health Insurance Company will provide an appeal determination not later than sixty (60) days after receipt of a request for review. If there are special circumstances, the decision will be made as soon as possible, but no later than fifteen (15) days after receipt of the request for review. The appeal determination will be in writing and will include specific reasons for the decision. This decision shall also include specific references to the Policy provisions on which the decision was based.

**Underwritten by BEST Life and Health Insurance Company**

**Individually Underwritten  
Association Insurance Policy**

**Dental PPO Plan**



[2505 McCabe Way  
Irvine, California 92614]

**Notice to Buyer: This Certificate provides dental coverage only.**

## CERTIFICATE OF GROUP INSURANCE

Issued By

**BEST Life and Health Insurance Company**

A STOCK COMPANY

(Herein called the "We," "Us," "Company" or "BEST Life")

**BEST Life and Health Insurance Company** certifies that Insureds are covered for the benefits described in this Certificate, subject to the limitations and exclusions of this Certificate and of the Policy. The Policy is the contract between BEST Life and the Policyholder named on the Schedule of Benefits. The Policy may be changed or ended without the consent of or notice to the Certificate holder.

This Certificate replaces any certificate previously issued by BEST Life.

**PLAN EFFECTIVE DATE:** Insurance is in effect on the date shown on the Certificate Statement of Coverage.

**GOVERNING JURISDICTION:** The Policy is issued in the State of California. It shall be construed in accordance with the laws of the issuing State.

BEST Life and Health Insurance Company's President and Secretary signed this at [2505 McCabe Way, Irvine, California 92614].



[

]

**President**



[

]

**Secretary**

**GROUP PPO DENTAL  
NON-PARTICIPATING**

**THIS INSURANCE DOES NOT COVER INJURIES OR ILLNESSES THAT HAPPEN IN THE COURSE AND SCOPE OF EMPLOYMENT. ASK YOUR PARTICIPATING EMPLOYER WHETHER YOU ARE PART OF A WORKERS' COMPENSATION SYSTEM.**

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**This Certificate Is Not Valid  
Unless There Is a Complete Statement of Coverage**

**Statement of Coverage**

**DENTAL**

**INSURANCE SUBSCRIBER NAME:** [JOHN D. DOE]  
**CERTIFICATE EFFECTIVE DATE:** [01/01/2014]

**INSURED NAME(S) AND EFFECTIVE DATE(S):**

[JANE DOE 01/01/2014]  
[JON DOE 01/01/2014]

**[PLAN:** [PPO HIGH]  
**DEDUCTIBLE:** [\$50]  
**ANNUAL MAXIMUM:** [\$1,000]]

**GROUP POLICY No.:** [XXXXXXXXXX]

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	Access to Care.....	[X]
	Advance Notice of Dental Treatment.....	[X]
	Deductibles.....	[X]
	Alternative Procedures.....	[X]
PART 4 -	EXCLUSIONS.....	[X]
PART 5 -	DEFINITIONS.....	[X]
PART 6 -	COVERAGE EFFECTIVE AND TERMINATION DATES.....	[X]
	Effective Date.....	[X]
	Termination of Insurance.....	[X]
PART 7 -	COORDINATION OF BENEFITS.....	[X]
PART 8 -	PREMIUM PROVISIONS.....	[X]
PART 9 -	GENERAL PROVISIONS .....	[X]
PART 10 -	FILING A DENTAL CLAIM.....	[X]

## PART 1 - SCHEDULE OF BENEFITS

This Certificate of Group Coverage is made valid on the effective dates shown for the listed Insureds on the Statement of Coverage.

The Policy is issued by **BEST Life and Health Insurance Company** to: [BEST Employers Association].

Covered Services received by Insured from a Network Provider are reimbursed at the Network Provider's contracted Fee Schedule. Covered Services received by Insured from an Out-of-Network Provider are reimbursed at the [80th or 90th] percentile of a Usual, Reasonable and Customary schedule. All Covered Services are subject to Cost Sharing as shown on this Schedule of Benefits.

[

Benefits Description	[PPO Dental High] Plan	
	In-Network [Network]	Out-of-Network
<b>Employer Contributory or Voluntary</b>	[Employer contributory][Voluntary]	
<b>Annual Maximum</b>	\$[1,000 – 1,500]	
<b>Annual Deductible</b> (Applies to Basic and Major) – 3 Deductible Maximum per Family	\$50	
<b>Preventive Care Services</b> Routine oral exam, cleanings, X-rays	100%	100%
<b>Basic Services</b> Filings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology	90%	80%
<b>Major Services</b> Crowns & gold filings, inlays, onlays & pontics, implants, fixed bridges, complete & partial dentures	60%	50%
<b>Major Services Waiting Period</b>	12 Months	
<b>Endodontic Services</b>	Basic	
<b>Periodontic Services</b>	Major	
<b>Oral Surgery Services</b>	Major	
<b>Dental Accident Benefit</b>	\$1,000	
<b>Child Orthodontic Coverage</b> Orthodontic Services Coinsurance Orthodontic Maximums – Calendar Year   Lifetime 12 Month Waiting Period	50% \$500   \$1,000	
<b>Usual and Customary Reimbursement</b>	Fee Schedule	80 <sup>th</sup> Percentile

]



[

[PPO Dental Mid] Plan		
Benefits Description	In-Network [Network]	Out-of-Network
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Annual Maximum	\$1,500	
Annual Deductible (Applies to Basic and Major) – 3 Deductible Maximum per Family	\$50	
<b>Preventive Care Services</b> Routine oral exam, cleanings, X-rays	100%	80%
<b>Basic Services</b> Filings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology	80%	80%
<b>Major Services</b> Crowns & gold filings, inlays, onlays & pontics, implants, fixed bridges, complete & partial dentures	50%	50%
<b>Major Services Waiting Period</b>	12 Months	
<b>Endodontic Services</b>	Major	
<b>Periodontic Services</b>	Major	
<b>Oral Surgery Services</b>	Major	
<b>Dental Accident Benefit</b>	\$1,000	
<b>Child Orthodontic Coverage</b> Orthodontic Services Coinsurance Orthodontic Maximums – Calendar Year   Lifetime 12 Month Waiting Period	50% \$500   \$1,000	
<b>Usual and Customary Reimbursement</b>	Fee Schedule	80 <sup>th</sup> Percentile

]

[

[PPO Dental Basic] Plan		
Benefits Description	In-Network [Network]	Out-of-Network
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Annual Maximum	\$1,000	
Annual Deductible (Applies to Basic and Major) – 3 Deductible Maximum per Family	\$50	
<b>Preventive Care Services</b> Routine oral exam, cleanings, X-rays	100%	80%
<b>Basic Services</b> Filings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology	80%	50%
<b>Major Services</b> Crowns & gold filings, inlays, onlays & pontics, implants, fixed bridges, complete & partial dentures	0%	0%
<b>Endodontic Services</b>	Major	
<b>Periodontic Services</b>	Major	
<b>Oral Surgery Services</b>	Major	
<b>Dental Accident Benefit</b>	\$1,000	
<b>Usual and Customary Reimbursement</b>	Fee Schedule	80 <sup>th</sup> Percentile

]
 [

Benefits Description	[PPO Dental Value] Plan	
	In-Network [Network]	Out-of-Network
<b>Employer Contributory or Voluntary</b>	[Employer contributory][Voluntary]	
<b>Annual Maximum</b>	\$1,000	
<b>Annual Deductible</b> (Applies to Basic and Major) – 3 Deductible Maximum per Family	\$50	
<b>Preventive Care Services</b> Routine oral exam, cleanings, X-rays	100%	80%
<b>Basic Services</b> Filings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology	50%	20%
<b>Major Services</b> Crowns & gold filings, inlays, onlays & pontics, implants, fixed bridges, complete & partial dentures	0%	0%
<b>Endodontic Services</b>	Major	
<b>Periodontic Services</b>	Major	
<b>Oral Surgery Services</b>	Major	
<b>Dental Accident Benefit</b>	\$1,000	
<b>Usual and Customary Reimbursement</b>	Fee Schedule	80 <sup>th</sup> Percentile

]

## PART 2 - BENEFITS

### Covered Services

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Certificate.

#### CLASS I - Preventive Dental Procedures include:

- (1) Routine oral examination and diagnosis not more often than twice every 12 months per individual;
- (2) Bitewing x-rays not more often than once every 12 months per individual;
- (3) Full mouth x-rays or panoramic films are limited to once every five years; any combination of eight or more x-rays (including but not limited to bitewings or periapicals/intraorals) will be combined into a full mouth x-ray series;
- (4) Prophylaxis not more often than once every six months per individual.

#### CLASS II - Basic Dental Procedures include:

- (1) Pathology;
- (2) All fillings other than lab fabricated restorations (composite fillings limited to permanent anterior and posterior teeth);
- (3) Emergency palliative treatment;

- (4) Limited oral exam not more than once every six months;
- (5) Simple extraction, excluding orthodontic extractions unless a orthodontic benefits are a Covered Dental Expense on this Plan;
- (6) Surgical extraction, including impaction:
  - (a) erupted tooth;
  - (b) soft tissue impaction;
  - (c) partial bony impaction;
  - (d) complete bony impaction;
- (7) General anesthesia or intravenous sedation when required for complex oral surgical procedures (partial and complete bony impacted extractions only);
- (8) Periodontics (tissues and gums);
- (9) Periodontal exam (not in addition to a routine oral exam);
- (10) Periodontal maintenance (limited to once every six months per individual following active periodontal treatment) and not on the same visit as a routine prophylaxis;
- (11) Periodontal scaling and root planing (limited to once every 36 months and to two quadrants per visit, and not in addition to a routine prophylaxis);
- (12) Endodontics (pulp capping and root canal); and
- (13) Oral surgery:
  - (a) root recovery (surgical removal of residual root);
  - (b) oral antral fistula closure;
  - (c) removal of a dentigerous or odontogenic cyst;
  - (d) incision and drainage of an abscess;
  - (e) removal of lateral exostosis;
  - (f) frenulectomy.

[**Note:** Unless the twelve (12) month waiting period requirement for Major Dentistry services has been met, the services below are not covered benefits for any treatment that began during the twelve (12) month period immediately following Your effective date of coverage.]

**CLASS III - Major Dental Procedures include:**

- (1) Inlays, onlays, crowns and other lab fabricated restorations (not including veneers);
- (2) Porcelain, porcelain fused to metal, or full gold crowns on permanent teeth;
- (3) Full or partial dentures or fixed bridgework or adding teeth to an existing denture, if required because of loss of functional natural teeth while the person is covered for this Benefit. The work must be done within 12 months after the extraction and while this coverage is in force;
- (4) Replacement or alteration of full or partial dentures or fixed bridgework caused by the following while coverage is in force:
  - (a) accidental injury requiring oral surgical treatment, or
  - (b) oral surgical treatment involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus or redundant tissue, provided the replacement or alteration is done within 12 months of the injury or surgical treatment.
- (5) Replacement of a full denture or bridgework if the replacement is made more than [seven] years after the date of installation, unless:
  - (a) such replacement is made necessary by the initial extraction of an adjoining functional natural tooth; or
  - (b) the prosthesis, while in the oral cavity, has been damaged beyond repair as a result of a non-chewing injury while covered;
- (6) Repair or reline of dentures and bridgework;
- (7) Implants, as an alternative to a fixed prosthetic, (limited to once in a lifetime per site). The cost of the fixed prosthetic will be applied to the total value of the implant and implant-related procedures, not to exceed the cost of the fixed prosthetic:

- (a) the surgical placement of endosteal implant body including healing cap, where the bone and soft tissues are sound and healthy;
- (b) implant supported prosthetics;
- (c) eosteal and transosteal implants will be covered at the cost of the endosteal implant (if performed, member is responsible for additional fees);
- (d) bone grafting and tooth extractions, provided the work is done while this coverage is in force;
- (e) implant maintenance.

[**Note:** Unless the twelve (12) month waiting period requirement for Orthodontic Procedures has been met, the services below are not covered benefits for any treatment that begin during the twelve (12) month period immediately following Your effective date of coverage.]

**[CLASS IV – Orthodontic Procedures Include:**

Provides orthodontic treatment for Dependent children until the end of the month of their 18<sup>th</sup> birthday, to be payable as follows:

- (1) All procedures performed in connection with orthodontic treatment subject to the coinsurance level, Calendar Year and Lifetime Maximum Benefit as defined in the Schedule of Benefits;
- (2) Benefits for the initial placement up to [1/3][1/2] of the Lifetime Maximum Benefit Amount, as an initial down payment;
- (3) Periodic follow-up visits will be payable on a monthly basis during the scheduled course of orthodontic treatment, up to the Lifetime Maximum Amount;
- (4) Orthodontic benefits end once braces are removed or at the cancellation of coverage, whichever comes first.]

**Supplemental Dental Accident Benefit**

This benefit provides 100% coverage, not subject to deductible or coinsurance, for injury to sound, natural teeth up to a maximum benefit amount of \$1,000. Predetermination must be submitted before benefits are payable.

**PART 3 - LIMITATIONS AND COST SHARING**

**ACCESS TO CARE**

**Using a Network Provider:**

BEST Life offers Insureds the option to save on out-of-pocket costs when care is provided by a Network Provider. A listing of General Dentists and Specialists is available. To find a Network Provider, please refer to the Network information provided on the ID Card.

**How to Select a Dentist:**

Insureds on this Plan may obtain dental services from any licensed dental professional in the United States. To use the Plan, Insureds may directly contact the dentist of their choice and make an appointment. Insureds are advised to bring their ID Card to their appointment. The dentist may require a copy of the Insured's ID Card to confirm eligibility on this Plan.

**How to Obtain a Referral:**

A dentist may determine that an Insured requires treatment from a dental provider that specializes in a type of dentistry (Specialist). The Insured does not need to contact BEST Life for a referral. The Insured can directly contact the Specialist to make an appointment. The Specialist may require information from the Insured's dentist to determine a treatment plan and may contact the dentist directly.

## ADVANCE NOTICE OF DENTAL TREATMENT

Subscriber or Insured should submit Advance Notice of Dental Treatment before treatment commences in order to obtain Predetermination of Covered Services, including services that are medically necessary. If dental services are performed without such Predetermination, We reserve the right to deny any claim submitted with respect to such Covered Services; provided however, that predetermination is not required for:

- (1) Covered Services for which the related expense is less than \$500 during any course of treatment ("course of treatment" means one treatment or one of a planned series of treatments resulting from dental examination);
- (2) Emergency treatment; or
- (3) Oral examination and prophylaxis.

Predetermination is required for the following dental services:

- (1) Crowns, Anterior, except with posts or root canal;
- (2) Crowns, two (2) or more Posterior, except with posts or root canal;
- (3) Inlays or Onlays, two (2) or more, except with posts or root canal;
- (4) Laminates;
- (5) Anterior composites;
- (6) Two (2) or more multiple surfaces;
- (7) Bridges – initial or replacement;
- (8) Eligible partial dentures – initial or replacement;
- (9) Periodontal surgery over \$500;
- (10) Full bony impactions, two (2) or more.

We will have thirty (30) days to furnish the provider with an Explanation of Benefits demonstrating whether the proposed treatment will be a Covered Service under this Policy.

## DEDUCTIBLES

**Annual Deductible:** The Annual Deductible shown in the Schedule of Dental Benefits will apply separately to each Insured. Each Insured must accumulate eligible expenses equal to the deductible amount.

## ALTERNATIVE PROCEDURES

If more than one treatment plan exists for a dental procedure, covered dental expenses will be based on the least expensive procedure that will produce a result that meets professionally recognized standards. If the Insured's provider elects the more expensive treatment, the Insured or Subscriber shall be responsible for any charges that are greater than the covered expense for the less expensive treatment.

## PART 4 – EXCLUSIONS

The following exclusions are not Covered Services. No payments will be made by Us for these services:

- (1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;

- (2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
- (3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
- (4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;
- (5) Services and supplies begun and not completed prior to the patient's effective date, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
- (6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
- (7) Pulp capping, if in conjunction with the installation of inlays, onlays or crowns and fillings or other lab fabricated restorations; including but not limited to inlays, onlays and crowns, preventative tests and examinations diagnostic casts and oral cancer screenings, and expenses incurred for sedative fillings, including charges for prescribed drugs, pre-medication or analgesia;
- (8) The initial installation of a prosthetic device (a fixed bridge, implant, or denture), including crowns and inlays which form abutments, to replace teeth missing before You were covered under the Policy, except when it also replaces a tooth that is extracted while covered unless such installation commences after You have remained continuously covered under this plan for at least three years immediately prior to the date such installation commences;
- (9) Implants, implant services and implant supported prosthetics are not covered for patients under the age of 16;
- (10) Expenses incurred for veneers and related procedures;
- (11) Replacement of a lost or stolen or discarded prosthetic device;
- (12) Adjustment, repairs or relines of prostheses for a period of one year from initial placement if the prostheses were paid for under this plan;
- (13) Expenses incurred for a core buildup will only be considered in conjunction with a crown;
- (14) If multiple endodontic treatments are necessary on the same tooth within a period of one year, the allowance will be made for only one procedure;
- (15) X-rays are considered an integral part of the endodontic procedure rather than a separate service and are therefore not eligible for benefits;
- (16) The extraction of immature erupting third molars and non-pathologic, asymptomatic third molar extractions;
- (17) Expenses for gross debridement allowed one time at the beginning of the periodontal treatment plan prior to pocket depth charting;
- (18) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
- (19) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are a Covered Dental Expense on this Plan;
- (20) Surgical procedures incidental to orthodontic treatment, including but not limited to, extraction of teeth solely for orthodontic reasons, exposure of impacted teeth, correction of micrognathia or macrognathia, or repair of cleft palate;
- (21) Charges for service provided for temporomandibular joint dysfunction (TMJ);
- (22) Expenses incurred for congenital or developmental malformations;
- (23) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
- (24) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits;
- (25) Chemotherapeutic agents and any other experimental procedures;

- (26) Charges in excess of Usual, Reasonable and Customary charges or in excess of the Calendar Year Maximum amount stated in the "Schedule of Dental Benefits" section of this Plan, or in excess of the Preferred Provider Fee Schedule;
- (27) Expenses that are applied toward satisfaction of a Deductible, if any;
- (28) Services and supplies performed outside of the United States of America;
- (29) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, Your lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;
- (30) Expenses for services for which You would not legally have to pay if there were no insurance;
- (31) Services not completed on or before the date of termination;
- (32) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
- (33) Any service or procedure not commonly found within the scope of practice by a licensed dentist. Such procedures are identified within the current Common Dental Terminology (CDT Codes) published by the American Dental Association;
- (34) Expenses incurred for services covered on a pediatric only dental plan.

## **PART 5 - DEFINITIONS**

**Annual:** The twelve (12) month period beginning on the effective date of the Certificate and ending on the termination date of the Certificate. The Annual time frame will be applied to the Deductible and the Annual Maximum amount.

**Annual Deductible:** The amount each Insured must satisfy before Benefits are payable by Us. To satisfy the Annual Deductible, the Insured must accumulate expenses for Covered Services equal to the Deductible amount shown on the Schedule of Benefits.

**Annual Maximum:** The maximum amount BEST Life will reimburse for covered services during a twelve (12) month period for each Insured person. Once the full Annual Maximum amount has been paid, no additional services will be reimbursed for the remainder of that year. The

**Certificate Effective Date:** The date shown on the Statement of Coverage as the Certificate Effective Date.

**Coinsurance:** The amount of an expense for a Covered Service that we will pay once the deductible is satisfied.

**Covered Service:** A service or supply listed as a Covered Service and not otherwise limited or excluded by this Certificate. A Covered Service must be provided by a doctor of medical dentistry or a doctor of dental surgery, or a dentist.

**Eligible Dependent:** Means:

- (1) Your lawful spouse or domestic partner and
- (2) Your or Your spouse's or domestic partner's child or children, including a natural child, step-child, foster child, lawfully adopted child or child in the process of being adopted, from the date of placement, or any child for whom You have been granted legal custody, provided they are [less than][between 20 and] 26 years of age; or
- (3) A child named in a Qualified Medical Child Support Order will be considered a dependent.

"Eligible Dependent" also means a dependent child, who upon reaching the termination age, is unable to sustain employment because of a permanent mental or physical handicap and You notify Us in writing within thirty-one (31) days after the termination age, the child will continue to qualify as a dependent under this plan, provided You and the dependent child continue to be insured under this plan, and the child continues to be handicapped and dependent upon You for support. This shall not apply to a dependent child who is beyond the termination age on the date You become eligible for dependent insurance under this Policy.

**Family Deductible:** The Family Deductible is satisfied when each of three (3) covered members of Your family satisfy the Annual Deductible. Once the combined costs of services provided by covered members of Your family is equal to the Family Deductible amount, no additional Deductible will be required for other insured family members for the remainder of the Calendar Year.

**Emergency Care:** A dental emergency where an acute disorder of oral health requires dental and/or medical attention, including broken, loose, or evulsed teeth caused by traumas; infections and inflammations of the soft tissues of the mouth; and complications of oral surgery, such as dry tooth socket.

**Grace Period:** A Grace Period of thirty-one (31) days from the due date will be allowed for payment of each premium after the first. This coverage will remain in effect during the Grace Period; provided the premium is paid before the end of the Grace Period.

**Insured:** The Subscriber or any Eligible Dependent of a Subscriber who is enrolled in and covered under the Policy.

**Network Provider:** A dental care professional that is contracted with Us and is part of the Network shown on the Schedule of Benefits.

**Out-of-Network Provider:** A dental care professional that is not a Network Provider.

**Plan:** Means any Plan providing benefits or services for or by reason of dental or treatment, which benefits or services are provided in: (1) group, blanket or franchise insurance coverage; (2) group practice and other group prepayment coverage; (3) group service Plans; (4) any coverage under labor management trustee Plans, union welfare Plans, Employer organization Plans or Employee benefit organization Plans; and (5) any coverage under governmental programs, and any coverage required or provided by any statute. For purposes of coordinating benefits under this Policy, the term "Plan" shall not include any plan of individual coverage or school or church accident type coverages.

The term "Plan" shall be construed separately with respect to each Policy, contract or other arrangement for benefits or services and separately with respect to that portion of such Policy, contract or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

**Statement of Coverage:** The proof of insurance issued to an individual insured under the Policy, outlining the insurance benefits and principle provisions applicable to the member.

**Subscriber:** The primary insured person as shown on the Statement of Coverage.

**Usual, Reasonable and Customary:** The charge for health care that is consistent with the average rate or charge for identical or similar services in a certain geographical area.



**You or Your:** Means the Insured.

## **PART 6 - COVERAGE EFFECTIVE AND TERMINATION DATES**

### **EFFECTIVE DATE**

**Coverage:** The Insured's coverage will take effect on the Insured's Effective Date as shown on the Statement of Coverage.

### **TERMINATION OF INSURANCE**

The Insured's coverage will stop on the earliest of the following dates:

- (1) the last day of the month in which the Subscriber stops being a member of the Association;
- (2) the last day of the month in which the Insured stops being a member of a class eligible for insurance under this plan;
- (3) the last day of the month in which the Subscriber requests coverage be cancelled;
- (4) the day before the due date of any premium that remains unpaid at the end of the Grace Period;
- (5) the date the Policy terminates;
- (6) the last day of the month in which an Insured stops meeting the definition of Eligible Dependent; or
- (7) the day the Insured moves outside of the service area for Insured's selected network. Insured may request a plan change if Insured moves within an area where an alternate plan is available.

BEST Life will notify Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of this insurance coverage.

## **PART 7 – COORDINATION OF BENEFITS**

**Benefits Subject to this Provision:** All of the benefits provided under the Policy are subject to this provision.

If an Insured is covered by two or more group health insurance policies, the policies may coordinate benefits. Group insurance was designed to cover dental expenses; however, it was never intended to pay in excess of 100% of incurred charges. Coordination of Benefits is established as a method by which two or more carriers or plans could coordinate their respective benefits so the total benefit paid does not exceed 100% of the total allowable expenses incurred.

When there are two or more group carriers involved, one of the carriers is primary and one is secondary. This continues for all carriers involved. The primary carrier pays first, the secondary carrier pays second. This continues for all carriers involved. The order of the carriers is determined, as follows:

**Dependent Children of Non-Separated or Divorced Parents:** The plan covering the parent whose birthday falls earlier in the year is the primary carrier for an Insured under this Certificate. If both parents have the same birthday, the plan that has provided coverage longer is the primary carrier.

**Dependent Children of Separated or Divorced Parents:** The plans must pay in the following order:

- First, the plan of the parent with custody of the child;

- Then, the plan of the spouse or domestic partner of the parent with custody of the child;
- Finally, the plan of the parent not having custody of the child.

However, if terms of a court decree state that one parent is responsible for the health care expenses of the child, and the insurance company has been advised of the responsibility, that plan is primary carrier over the plan of the other parent.

**Dependent Children of Parents With Joint Custody:** The birthday rule applies in this situation.

**Right to Receive and Release Necessary Information:** For the purpose of determining the applicability of and implementing the terms of this provision of this Plan or any provisions of similar purpose of any other Plan, We may, with the consent of any person, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which We deem to be necessary for such purposes. Such information may include information for payment of claims, information to administer your benefits or information to determine medical necessity with our case manager. Any person claiming benefits under this Plan shall furnish to Us such information as may be necessary to implement this provision.

**Facility of Payment:** Whenever payments which should have been made under this Plan in accordance with the Policy have been made under any other Plans, We shall have the right to pay over to any organizations making such other payments any amounts to satisfy our obligation under the Policy, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, We shall be fully discharged from liability under this Plan.

**Right to Recovery:** Whenever payments have been made by Us with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, We shall have the right to recover such payments, to the extent of such excess, from among one or more of the following: any persons to or for or with respect to whom such payments are made, any other insurers, service Plans or any other organizations.

## **PART 8 –PREMIUM PROVISIONS**

**Premium Payments:** Renewal premiums are payable to the Company. The payment of any premium shall not continue this Policy in force beyond the next premium due date, except as provided in the Grace Period provision.

**Changes in Premiums:** We may change the amount of the required premium due from the Policyholder by giving the Policyholder at least sixty (60) days advance written notice. During the first 12 months, We will not change the amount of the required premium.

**Grace Period:** This Policy has a thirty-one (31) day Grace Period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following thirty-one (31) days. During the Grace Period, this Policy will remain in force. If the required premium is not paid by the end of this Grace Period, this Policy will lapse as of the end of the Grace Period.

**Termination of Policy:** We may terminate this Policy at any time following the first renewal date by giving the Policyholder written notice at least sixty (60) days in advance. The Policyholder may also terminate this Policy by giving Us written notice at least sixty (60) days before the intended termination date. This Policy will also terminate if the required premium is not paid by the Policyholder as provided in the Grace Period provision.

**Reinstatement:** If any renewal premium is not paid by the end of the Grace Period, coverage under this Policy will be terminated. However, BEST Life will reinstate this Policy, without requiring an application for reinstatement, as long as premium is paid for at least the sixty (60) days prior to the date of reinstatement. The reinstated Policy will cover only loss resulting from an accidental injury sustained after the date of reinstatement and loss due to sickness beginning ten (10) days after reinstatement. In all other respects the insured and BEST Life shall have the same rights as they had under the Policy immediately before the due date of the defaulted premium, subject to conditions and provisions of the Policy.

## **PART 9 – GENERAL PROVISIONS**

**Clerical Error:** Clerical error by the Policyholder shall not invalidate insurance otherwise validly in force nor continue insurance otherwise validly terminated.

**Third Party Responsibility:** If an Insured is injured or becomes ill through the act or omission of another person, to the extent that the Insured recovers medical expenses for the same Injury or Illness from a third party or its insurer, We will be entitled to a repayment of any remuneration in excess of benefits paid under the Policy due to the same Injury or Illness, and after the Insured is fully compensated for his or her loss. We may file a lien for such repayment. Upon request, the Insured must complete and return the required forms to Us.

The repayment agreement will be binding upon the Insured, or the legal representative of a minor or incompetent, whether:

- (1) the payment received from the third party, or its insurer, is the result of:
  - legal judgment;
  - an arbitration award;
  - a compromise settlement;
  - any other arrangements; or
- (2) the third party or its insurer had admitted liability for the payment; or
- (3) the medical expenses are itemized in the third party payment.

**Entire Contract; Changes:** The Policy, including the endorsements, certificates, riders, application and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions. We will consider any statement made by the Insured or the Policyholder, in the absence of fraud, as a representation and not a warranty.

**Underwriting Decisions:** If, for any reason, We cannot accept Your application for coverage, We will communicate Our decision to You in writing with the reasons supporting Our decision.

**Notification to Insureds:** BEST Life will notify Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of your insurance, a change in your premium, a change in eligibility or a change in your benefits. This notice will be given to the appropriate insurance producer and the appropriate administrator, if any, along with non-employee certificate holders.

**Right to Contest:** After this Policy has been in force for a period of two (2) years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application. No claim for loss incurred or disability (as defined in the

Policy) commencing after two (2) years from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Policy.

**Notice of Claim:** We must receive written notice within twenty (20) days after a claim starts or as soon as reasonably possible. The notice shall be sent to BEST Life and Health Insurance Company at [2505 McCabe Way, Irvine, California 92614] or given it to Our agent.

**Claim Forms:** When We receive a notice of claim, We will send forms for filing the claim. If the Subscriber or Insured do not receive these forms within fifteen (15) days, the Subscriber or Insured may send Us a written statement to satisfy this requirement. This statement should include the nature and extent of the claim and be sent to Us within the time stated in the Proof of Loss provision.

**Proof of Loss:** We must receive written proof of loss within ninety (90) days of a claim. If it is not possible for proof to be provided within the ninety (90) days, We will not deny a claim for this reason if We receive the proof as soon as possible. In any event, We must receive proof no later than one year from the time specified, unless Subscriber is legally incapacitated.

**Time of Payment of Claims:** Indemnities payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this Policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

**Payment of Claims:** All payments will be made to Subscriber or Insured's provider.

**Legal Actions:** A legal action may not be brought against Us before sixty (60) days, or after three (3) years, from the date written proof of loss is required to be given.

**Time Limit on Certain Defenses:** After this Policy has been in force for two (2) years, We will not use any statements made in the application of the Policyholder to void the Policy. After an Insured Person has been covered under this Policy for two (2) years, We will not use any statement made in the Insured Person's enrollment form to defend a claim.

**Misstatement of Age:** If the age of any individual covered under the Policy has been misstated, there shall be an adjustment of premium for the Policy so that there shall be paid to Us the premium for the coverage of such individual at his or her correct age, and the amount of the insurance coverage shall not be affected.

**Worker's Compensation:** The Policy is not in lieu of and does not affect any requirement for coverage by Worker's Compensation Insurance.

**Conformity with State Statutes:** Any provisions of the Policy which are in conflict with the statutes of the state in which the Policy was issued or delivered will be changed to conform to such laws.

**Waiver of Rights:** If We fail to enforce any provision of the Policy, such failure will not affect Our right to do so at a later date, nor will it affect Our right to enforce any other provision of the Policy.

**Inspection of Policy:** The Policy is in the possession of the Policyholder. It may be inspected at any time during business hours at the office of the Policyholder.

**Duty to Cooperate:** As a condition precedent to the payment of benefits hereunder, the Subscriber and Insured are required to cooperate with Us by providing all information reasonably required to accurately process a claim. Any failure to provide necessary information may result in a denial of benefits for the claim.

## **PART 10 – FILING A DENTAL CLAIM**

**HOW TO FILE A CLAIM:** Claim forms may be obtained from [the BEST Life website located at [www.bestlife.com](http://www.bestlife.com), click on “Forms”].

Submit claims to [BEST Life and Health Insurance Company], [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

For questions about a claim payment, contact BEST Life’s Customer Service at [1-800-433-0088 or at [cs@bestlife.com](mailto:cs@bestlife.com), Monday through Friday, 7 am to 5 pm Pacific Time].

**CLAIMS DENIAL PROCEDURE:** Any denial of a claim for Benefits will be explained in writing. The explanation will include (a) the specific reason for the denial, (b) reference to the plan provision upon which the denial was based, (c) a description of any additional information that might be required to provide and an explanation of why it is needed, and (d) an explanation of the plan's claim review procedure.

**APPEALING THE DENIAL OF A CLAIM:** You or an authorized representative You appoint to assist or represent You, may appeal any denial of a claim, in whole or in part, for Benefits by filing a written request for a review. The request must include all reasons You believe the initial decision was incorrect and all documentation supporting Your appeal, to BEST Life and Health Insurance Company, Attn: Appeals, [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

A request for a review must be filed within one-hundred and eighty (180) days after the date on which we issue the written notice of denial of a claim. BEST Life and Health Insurance Company will provide an appeal determination not later than sixty (60) days after receipt of a request for review. If there are special circumstances, the decision will be made as soon as possible, but no later than fifteen (15) days after receipt of the request for review. The appeal determination will be in writing and will include specific reasons for the decision. This decision shall also include specific references to the Policy provisions on which the decision was based.

**Underwritten by BEST Life and Health Insurance Company**

## VARIABILITY STATEMENT

GAD-IM-PPO-POL-  
0113TN

**Title Page** – The address and officers of the company may change; Policy.

**Page 2** – The President and Secretary of the company may change.

**Page 3** – Specific to the Client.

**Policyholder** – Is the BEST Employers Association. Is bracketed to allow this product to be offered to other Associations.

**Schedule of Benefits** – we are offering four plan designs. We have provided the full range of possibilities that would apply. In the final Certificate, only the plan that was selected will appear.

**Major Dentistry Waiting Period Waiver** – Our plans with a 12-month wait for Major Services may have the waiting period waived based on prior coverage. This section is bracketed and will only appear for plans with a 12-month wait. Plans without a 12-month wait will not have this information in their Certificate.

**Part 2 Benefits** – We may offer a 12-month wait on Major and Orthodontic Services. A statement disclosing this is bracketed. Plans without a 12-month wait will not have this in their certificate. Orthodontic benefits are bracketed since this is an optional benefit only. Plans that do not have Orthodontia will not have this information provided in their Certificate.

**CLASS IV – Orthodontic Procedures** – will only appear on plans that include coverage for child Orthodontia. Payment may be offered at 1/3 or 1/2 of the Lifetime Maximum Benefit. Only one of these will be chosen at the time we implement these plans. It is bracketed in case we want to change this benefit for new contracts at a later time.

**Definitions** – Eligible Dependent (2), the limiting age is bracketed so that employers with pediatric benefits embedded in their medical plan have the option of defining eligible children as those between 20 and 26 years of age.

**Effective Date for the Employee** - Item #3 is bracketed and will be specific to the Client. The Client may not want coverage effective on the date the employee qualifies.

### General Provisions

- **Notice of Claim** – Address may change.

### Filing a Dental Claim

- How to file a claim – URLs and contact information are bracketed to allow for changes, and possibly a third party administrator. Right now, there is no contract with a third party administrator, so BEST Life's current contact information is provided.
- Appealing the denial of a claim – address may change.

**Title Page** – The address of the company may change.

**Page 2** – The President and Secretary of the company may change.

**Statement of Coverage** – Group and Insured information will be provided in the bracketed fields.

- **Subscriber Name** – Specific to individual purchasing the plan.
- **Certificate Effective Date** – Specific to the plan year for the Exchange.
- **Insured name(s) and Effective Dates(s)** – specific to client.
- **Participating employer name and number** – specific to the client.
- **Plan information** – We are transitioning to a new administrative system. Our current administrative system provides plan selection information in the Statement of Coverage. The new administrative system will provide this information in the Schedule of Benefits. The Plan, Deductible, and Annual Maximum is bracketed because these fields will no longer be provided once the new system is up and running.
- **Group Policy Number** – Specific to the client.

**Policyholder** – Is the BEST Employers Association. Is bracketed to allow this product to be offered to other Associations.

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#### **General Provisions**

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#### **Filing a Dental Claim**



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